FIRST SENIORITY®

Harvard Pilgrim Health Care

Benefit Handbook

Your Medicare Health Benefits and Services for Group Insurance Commission Retiree Members of the Harvard Pilgrim Health Care, *First Seniority* Plan

Massachusetts and New Hampshire

January 1 – December 31, 2006

Commonwealth of Massachusetts
Group Insurance Commission

This booklet gives the details about your Medicare health coverage and explains how to get the care you need. This booklet is an important legal document. Please keep it in a safe place.

Harvard Pilgrim Member Services:

For help or information, please call Member Services weekdays. Hours of operation are: 8:00 a.m. - 7:30 p.m. on Monday and Wednesday, and 8:00 a.m. - 5:30 p.m. on Tuesday, Thursday and Friday. Calls to these numbers are free:

1-800-421-3550

TTY: 1-800-421-3599

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Welcome to *First Seniority*!

Welcome to *First Seniority.*

We are pleased that you've chosen *First Seniority*.

First Seniority is an is a **H**ealth **M**aintenance **O**rganization (HMO) for people with Medicare
Now that you are enrolled in *First Seniority*, you are getting your care through Harvard Pilgrim Health Care (Harvard Pilgrim). *First Seniority*, an HMO, is offered by Harvard Pilgrim. ***First Seniority* is *not* a "Medigap" or supplemental Medicare insurance policy.**

This booklet explains how to get your Medicare services through *First Seniority*

This booklet, together with your enrollment form and any amendments that we may send to you, is our contract with you. It explains your rights, benefits, and responsibilities as a Member of *First Seniority*. It also explains our responsibilities to you. The information in this booklet is in effect for the time period from January 1, 2006, through December 31, 2006.

You are still covered by Original Medicare, but you are getting your Medicare services as a member of *First Seniority*. This booklet gives you the details, including:

- What is covered in *First Seniority* and what is not covered.
- How to get the care you need, including some rules you must follow.
- What you will have to pay for your health plan.
- What to do if you are unhappy about something related to getting your Covered Services.
- How to leave *First Seniority*, and other Medicare options that are available.

If you need to receive this booklet in a different format (such as in Spanish), please call us. Section 1 of this booklet tells how to contact us.

Please tell us how we're doing

We want to hear from you about how well we are doing as your health plan. You can call or write to us at any time (Section 1 of this booklet explains how to contact us). Your comments are always welcome, whether they are positive or negative. From time to time, we do surveys that ask our members to tell us about their experiences with *First Seniority*. If you are contacted, we hope you will participate in a member satisfaction survey. Your answers to the survey questions will help us know what we are doing well and where we need to improve.

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How to contact Harvard Pilgrim Member Services

If you have any questions or concerns, please call or write to Harvard Pilgrim Member Services. We will be happy to help you. Our business hours are 8:00 a.m. - 7:30 p.m. on Monday and Wednesday, and 8:00 a.m. - 5:30 p.m. on Tuesday, Thursday and Friday.

CALL	**1-800-421-3550**. This number is also on the cover of this booklet for easy reference. Calls to this number are free.
TTY	**1-800-421-3599**. This number requires special telephone equipment. It is on the cover of this booklet for easy reference. Calls to this number are free.
WRITE	Harvard Pilgrim Health Care, *First Seniority* Member Services, 1600 Crown Colony Drive, Quincy, MA 02169

How to contact the Medicare program and 1-800-MEDICARE (TTY 1-877-486-2048) helpline

Medicare is the federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant). CMS is the federal agency in charge of the Medicare program. CMS stands for **C**enters for **M**edicare & Medicaid **S**ervices. CMS contracts with and regulates Medicare Health Plans (including Harvard Pilgrim) and Medicare Private Fee-for-Service organizations.

Here are ways to get help and information about Medicare from CMS:

- Call **1-800-MEDICARE** (1-800-633-4227) to ask questions or get free information booklets from Medicare. You can call this national Medicare helpline 24 hours a day, 7 days a week. The TTY number is 1-877-486-2048 (you need special telephone equipment to use this number). Calls to these numbers are free.
- Use a computer to look at www.medicare.gov, the official **government website for Medicare information.** This website gives you a lot of up-to-date information about Medicare and nursing homes and other current Medicare issues. It includes booklets you can print directly from your computer. It has tools to help you compare Medicare Advantage Plans and Prescription Drug Plans in your area. You can also search the "Helpful Contacts" section for the Medicare contacts in your state. If you do not have a computer, your local library or senior center may be able to help you visit this website using their computer.

SHINE– an organization in Massachusetts that provides free Medicare help and information

Serving Health Information Needs of Elders (SHINE) is a state organization paid by the Federal Government to give free health insurance information and help to people with Medicare. SHINE can explain your Medicare rights and protections, help you make complaints about care or treatment, and help straighten out problems with Medicare bills. SHINE has information about Medicare Advantage plans and about Medigap (Medicare supplement insurance) policies. This includes information about whether to drop your Medigap policy while enrolled in the Medicare Advantage plan. This also includes special Medigap rights for people who have tried a Medicare Advantage plan (like *First Seniority*) for the first time. (Medicare Advantage is the new name for Medicare+Choice). Section 6 has more information about your Medigap guaranteed issue rights.

You can contact SHINE at Massachusetts Executive Office of Elder Affairs, One Ashburton Place, Boston, MA 02108. The phone number in your area is: 1-800-882-2003 or 1-800-872-0166 (TTY). You can also find the website for SHINE at www.medicare.gov on the web.

HICEAS– an organization in New Hampshire that provides free Medicare help and information

The Health Insurance Counseling Education and Assistance Services (HICEAS) is a state organization paid by the Federal Government to give free health insurance information and help to people with Medicare. HICEAS can explain your Medicare rights and protections, help you make complaints about care or treatment, and help straighten out problems with Medicare bills. HICEAS has information about Medicare Advantage plans and about Medigap (Medicare supplement insurance) policies. This includes information about whether to drop your Medigap policy while enrolled in the Medicare Advantage plan. This also includes special Medigap rights for people who have tried a Medicare Advantage plan (like *First Seniority*) for the first time.

You can contact HICEAS at P.O. Box 2338, Concord, NH 03302-2338. The phone number in your area is: 1-603-225-9000 or 1-800-852-3388; for TTY access, you may call Relay NH at 1-800-735-2964. You can also find the website for HICEAS at www.medicare.gov on the web.

For members who reside in Massachusetts

MassPro/Quality Improvement Organization (QIO) – a group of doctors and health professionals in your state who review medical care and handle certain types of complaints from patients with Medicare

"QIO" stands for **Q**uality **I**mprovement **O**rganization. The QIO is a group of doctors and other health care experts paid by the Federal Government to check on and help improve the care given to Medicare patients. There is a QIO in each state. QIOs have different names, depending on which state they are in. In Massachusetts, the QIO is called MassPro. The doctors and other health experts in MassPro review certain types of complaints made by Medicare patients. These include complaints about quality of care and complaints from Medicare patients who think the coverage for their hospital, skilled nursing facility, home health agency or comprehensive outpatient rehabilitation stay is ending too soon. See section 10 for more information about complaints.

You can contact MassPro at 235 Wyman Street, Waltham, MA 02154. The phone number in your area is 1-781-890-0011.

For members who reside in New Hampshire

Northeast HealthCare Quality Foundation/Quality Improvement Organization (QIO) – a group of doctors and health professionals in your state who review medical care and handle certain types of complaints from patients with Medicare

"QIO" stands for **Q**uality **I**mprovement **O**rganization. The QIO is a group of doctors and other health care experts paid by the Federal Government to check on and help improve the care given to Medicare patients. There is a QIO in each state. QIOs have different names, depending on which state they are in. In New Hampshire, the QIO is called Northeast HealthCare Quality Foundation. The doctors and other health experts in Northeast HealthCare Quality Foundation review certain types of complaints made by Medicare patients. These include complaints about quality of care and complaints from Medicare patients who think the coverage for their hospital, skilled nursing facility, home health agency or comprehensive outpatient rehabilitation stay is ending too soon. See section 10 for more information about complaints.

You can contact Northeast HealthCare Quality Foundation at 12 Old Rollinsford Road Suite 302, Dover, NH. The phone number in your area is 1-800-772-0151 or 1-603-749-1641 and the fax number is: 1-603-749-1195.

Other organizations (including Medicaid and the Social Security Administration)

Medicaid agency – a state government agency that handles health care programs for people with low incomes

Medicaid is a joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Some people with Medicare are also eligible for Medicaid. Most health care costs are covered if you qualify for both Medicare and Medicaid. Medicaid also has programs that can help pay for your Medicare premiums and other costs, if you qualify.

For members who reside in Massachusetts
To find out more about Medicaid and its programs, contact the Office of Medicaid (Mass Health) at 1-800-841-2900 or 1-800-497-4648 (TTY) for the hearing impaired (you need special telephone equipment to use this number).

For members who reside in New Hampshire
To find out more about Medicaid and its programs, contact the New Hampshire Department of Health and Human Services at 1-800-852-3345 or 1-800-735-2964 (TTY) for the hearing impaired (you need special telephone equipment to use this number).

Social Security Administration

The Social Security Administration provides economic protection for Americans of all ages. Social Security programs include retirement benefits, disability, family benefits, survivors' benefits, and benefits for the aged, blind and disabled. You can call the Social Security Administration at 1-800-772-1213. The TTY number is 1-800-325-0778 (you need special telephone equipment to use this number). Calls to these numbers are free. You can also visit **www.ssa.gov** on the web.

Railroad Retirement Board

If you get benefits from the Railroad Retirement Board, you can call your local Railroad Retirement Board office or 1-800-808-0772 (calls to this number are free). The TTY number is 312-751-4701 (you need special telephone equipment to use this number). You can also visit www.rrb.gov on the web.

Employer (or "Group") Coverage

Call the Group Insurance Commission at 617-727-2310 directly if you have any questions about your plan premiums or the open enrollment season.

SECTION 2 Getting the care you need, including some rules you must follow

Section 6 describes our coverage rules associated with our outpatient prescription drug coverage.

What is First Seniority?

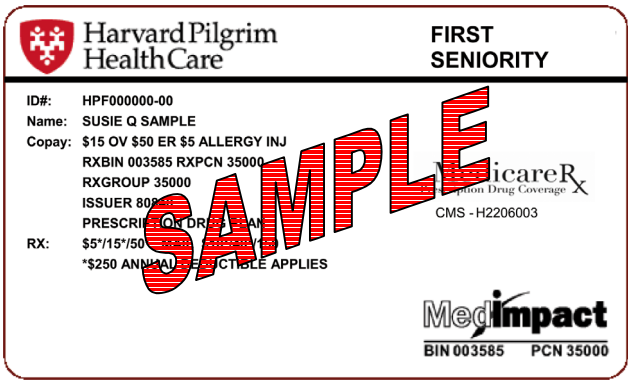
Now that you are enrolled in *First Seniority*, you are getting your Medicare through Harvard Pilgrim. *First Seniority* is offered by Harvard Pilgrim, and is an HMO for people with Medicare. The Medicare program pays us to manage health services for people with Medicare who are members of *First Seniority*. (*First Seniority* is **not** a Medicare supplement policy. See Section 15 for a definition of Medicare supplement policy. Medicare supplement policies are sometimes called "Medigap" insurance policies.) Harvard Pilgrim provides medical services through Medicare-certified health care facilities. In addition, our health care professionals are in compliance with Medicare credentialing standards.

This booklet explains your benefits and services, what you have to pay, and the rules you must follow to get your care. *First Seniority* gives you all of the usual Medicare services that are covered for everyone with Medicare. We also give you some additional service and supplies, such as eyeglasses, hearing aids and routine physicals.

Since *First Seniority* is a Medicare HMO, this means that you will be getting most or all of your health services from the doctors, hospitals, and other health providers that are part of *First Seniority*. Since these doctors, hospitals, and other providers are the ones we are paying to provide your care, they are the ones you must use (except in special situations such as emergencies).

Use your plan membership card instead of your red, white, and blue Medicare card

Now that you are a member of *First Seniority*, you have a *First Seniority* membership card. Here is a sample card to show what it looks like:



During the time you are a plan member and using plan services, **you *must* use your plan membership card instead of your red, white, and blue Medicare card to get Covered Services.** (See Section 4 for a definition and list of Covered Services.) Keep your red, white, and blue Medicare card in a safe place in case you are asked to show it, but for the most part you will not use it to get services while you are a member. If you get covered services using your red, white, and blue Medicare card instead of your *First Seniority* membership card while you are a plan member, the Medicare program will not pay for these services and you may have to pay the full cost yourself.

Please carry your *First Seniority* membership card with you at all times. You will need to show this card when you get Covered Services. You will also need it to get your prescriptions at the pharmacy. If your membership card is ever damaged, lost, or stolen, call Member Services right away and we will send you a new card.

Help us keep your Member records up to date

Harvard Pilgrim has a file of information about you as a plan member. Doctors, hospitals, pharmacists and other Plan Providers use this membership record to know what services and prescription drugs are covered for you. The Member record has information from your enrollment form, including your address and telephone number. It shows your specific *First Seniority* coverage, the *Primary Care Physician* you chose when you enrolled, and other information. Section 9 tells how we protect the privacy of your personal health information.

Please help us keep your member record up to date by letting Member Services and the Group Insurance Commission know right away if there are any changes in your name, address, or phone number, or if you go into a nursing home. Also, tell Member Services about any changes in health insurance coverage you have from other sources, such as from your employer, your spouse's employer, workers' compensation, Medicaid, or liability claims such as claims against another driver in an automobile accident. See Section 1 for how to contact Member Services.

What is the geographic service area for First Seniority?

THE TOWNS & CITIES IN OUR MASSACHUSETTS SERVICE AREA ARE LISTED BELOW.

Abington
Accord
Acton
Amesbury
Andover
Arlington
Ashburnham
Ashby
Ashland
Assonet
Attleboro
Attleboro Falls
Avon
Ayer
Bedford
Bellingham
Belmont
Berkley
Berlin
Beverly
Billerica
Blackstone
Bolton
Boston
Boxboro
Boxford
Boylston
Braintree
Brant Rock
Bridgewater
Brockton
Brookline
Bryantville
Burlington
Byfield
Cambridge
Canton
Carlisle
Carver
Chartley
Chelmsford
Chelsea
Clinton
Cohasset
Concord
Danvers
Dedham
Devens
Dighton
Dover
Dracut
Dunstable
Duxbury
East Bridgewater
East Princeton
East Taunton
Easton
Elmwood
Essex
Everett
Fall River
Fayville
Fitchburg
Foxboro
Framingham
Franklin
Gardner
Georgetown
Gloucester
Grafton
Greenbush
Green Harbor
Groton
Groveland
Halifax
Hamilton
Hanscom AFB
Hanson
Harvard
Hathorne
Haverhill
Hingham
Holbrook
Holliston
Hopedale
Hopkinton
Hudson
Hull
Humarock
Ipswich
Jefferson
Kingston
Lakeville
Lancaster
Lawrence
Leominster
Lexington
Lincoln
Linwood
Littleton
Lowell
Lunenburg
Lynn
Lynnfield
Malden
Manchester
Manchester-by-the-Sea
Mansfield
Marblehead
Marlboro
Marshfield
Marshfield Hills
Maynard
Medfield
Medford
Medway
Melrose
Mendon
Merrimac
Methuen
Middleboro
Middleton
Milford
Millbury
Millis
Millville
Milton
Minot
Monponsett
Nahant
Natick
Needham
Newbury
Newburyport
Newton
Norfolk
N. Andover
N. Attleboro
N. Carver
N. Dighton
N. Easton
N. Grafton
N. Marshfield

N. Pembroke
N. Reading
N. Scituate
N. Uxbridge
Northborough
Northbridge
Norton
Norwell
Norwood
Nutting Lake
Ocean Bluff
Peabody
Pembroke
Pepperell
Plainville
Plymouth
Plympton
Prides Xing
Princeton
Quincy
Randolph
Raynham
Raynham Center
Reading
Rehoboth
Revere
Rockland
Rockport
Rowley
Salem
Salisbury
Saugus
Scituate
Seekonk
Sharon
Sherborn
Shirley
Shrewsbury
Somerset
Somerville
South Easton
South Grafton
South Lancaster
Southborough
Sterling
Still River
Stoneham
Stoughton
Stow
Sudbury
Swampscott
Swansea
Taunton
Tewksbury
Topsfield
Townsend
Tyngsboro
Upton
Uxbridge
Wakefield
Walpole
Waltham
Watertown
Waverley
Wayland
Wellesley
Wenham
West Boylston
West Bridgewater
West Millbury
West Newbury
Westborough
Westford
Westminster
Weston
W. Newbury
Westwood
Weymouth
Whitinsville
Whitman
Wilmington
Winchester
Winthrop
Woburn
Woodville
Worcester
Wrentham

THE TOWNS & CITIES IN OUR NEW HAMPSHIRE SERVICE AREA ARE LISTED BELOW:

Amherst
Atkinson
Auburn
Bedford
Bow
Brookline
Candia
Chester
Danville
Derry
Dunbarton
East Candia
East Derry
East Hampstead
Goffstown
Greenville
Hampstead
Hollis
Hooksett
Hudson
Kingston
Litchfield
Londonderry
Lyndeborough
Manchester
Merrimack
Milford
Mont Vernon
Nashua
New Boston
New Ipswich
Newton
Newton Junction
North Salem
Pelham
Plaistow
Portsmouth
Raymond
Rindge
Salem
Sandown
Temple
Wilton
Windham

Using Plan Providers to get services covered by First Seniority

You will be using Plan Providers to get your Covered Services

Now that you are a member of *First Seniority*, with few exceptions, **you must use Plan Providers to get your Covered Services.**

- **What are "Plan Providers"?** "Providers" is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. We call them "Plan Providers" when they participate in *First Seniority*. When we say that Plan Providers "participate in *First Seniority*," this means that we have arranged with them to coordinate or provide Covered Services to members of *First Seniority*.
- **What are "Covered Services"?** "Covered Services" is the general term we use in this booklet to mean all of the health care services and supplies that are covered by *First Seniority*. Covered Services are listed in the Benefits Chart in Section 4.

As we explain below, you will have to choose one of our Plan Providers to be your PCP, which stands for Primary Care Physician. Your PCP will provide or arrange for most or all of your Covered Services. Care or services you get from non-Plan Providers will not be covered, with few exceptions such as emergencies. (When we say "non-Plan Providers," we mean providers that are **not** part of *First Seniority*.)

The Provider Directory gives you a list of Plan Providers

Every year as long as you are a member of *First Seniority,* we will send you a Provider Directory, which gives you a list of Plan Providers. If you don't have the Provider Directory, you can get a copy from Member Services (see Section 1 for how to contact Member Services). You can ask Member Services for more information about Plan Providers, including their qualifications and experience. Member Services can give you the most up-to-date information about changes in Plan Providers and about which ones are accepting new patients.

Access to care and information from Plan Providers

You have the right to get timely access to Plan Providers and to all services covered by the plan. ("Timely access" means that you can get appointments and services within a reasonable period of time.) You have the right to get full information from your doctors when you go for medical care. You have the right to participate fully in decisions about your health care, which includes the right to refuse care. Please see Section 9 for more information about these and other rights you have, and what you can do if you think your rights have not been respected.

Choosing Your PCP (PCP means Primary Care Physician)

What is a "PCP"?

When you become a member of *First Seniority,* you must choose a Plan Provider to be your PCP. Your PCP is a *health care professional* who meets State requirements and is trained to give you basic medical care. As we explain below, you will get your routine or basic care from your PCP. Your PCP will also coordinate the rest of the Covered Services you get as a plan member. For example, in order to see a specialist, you usually need to get your PCP's approval first (this is called getting a "referral" to a specialist).

How do you choose a PCP?

Members must choose a PCP who practices in the state where the member resides, therefore, when choosing your PCP, be sure to select a Massachusetts based PCP if you reside in Massachusetts or a New Hampshire based PCP if you reside in New Hampshire, by using the Provider Directory or getting help from Member Services. You can reach Member Services at **1-800-421-3550** (Hours of operation are 8:00 a.m. - 7:30 p.m. on Monday and Wednesday, and 8:00 a.m. - 5:30 p.m. on Tuesday, Thursday and Friday.) A Member Services representative will be happy to assist you. Hearing impaired Members can contact Member Services by calling the TTY Machine at **1-800-421-3599**. When you select your PCP, it is important to remember that this will limit you to the hospital, outpatient facilities and panel of specialists in the provider network contracted with your PCP. If there is a particular *First Seniority* specialist or hospital that you want to use, check first to be sure your PCP makes referrals to that specialist, or uses that hospital.

Getting care from your PCP

You will usually see your PCP first for most of your routine health care needs. As we explain below and in Section 4, there are only a few types of Covered Services you can get on your own, without contacting your PCP first.

Besides providing much of your care, your PCP will help arrange or coordinate the rest of the Covered Services you get as a plan member. This includes your x-rays, laboratory tests, therapies, care from doctors who are specialists, hospital admissions, and follow-up care. "Coordinating" your services includes checking or consulting with other Plan Providers about your care and how it is going. If you need certain types of Covered Services or supplies, your PCP must give approval in advance (such as giving you a referral to see a specialist). In some cases, your PCP will also need to get prior authorization. Since your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your new PCP's office. Section 9 tells how we will protect the privacy of your medical records and personal health information.

What if you need medical care when your PCP's office is closed?

What to do if you have a medical emergency or urgent need for care

In an emergency, you should get care immediately. You do **not** have to contact your PCP or get permission in an emergency. You can dial 911 for immediate help by phone, or go directly to the nearest emergency room, hospital, or urgent care center. Section 3 tells what to do if you have a medical emergency or urgent need for care.

What to do if it is not a medical emergency

If you need to talk with your PCP or get medical care when the PCP's office is closed, and it is *not* a medical emergency, call your PCP's office number. There will always be a *health professional* on call to help you.

See Section 3 for more information about what to do if you have an urgent need for care.

Getting care from specialists

When your PCP thinks that you need specialized treatment, he or she will give you a referral (approval in advance) to see a plan specialist. A specialist is a doctor who provides health care services for a specific disease or part of the body. Examples include oncologists (who care for patients with cancer), cardiologists (who care for patients with heart conditions), and orthopedists (who care for patients with certain bone, joint, or muscle conditions). For some types of referrals to plan specialists, your PCP may need to get approval in advance from Harvard Pilgrim (this is called getting "prior authorization").

It is very important to get a referral from your PCP before you see a plan specialist (there are a few exceptions, including routine women's health care, that we explain later in this section). **If you don't have a referral before you receive services from a specialist, you may have to pay for these services yourself.** If the specialist wants you to come back for more care, check first to be sure that the referral you got from your PCP covers more visits to the specialist.

If there are specific specialists you want to use, find out whether your PCP sends patients to these specialists. Each plan PCP has certain plan specialists they use for referrals. This means that **the *First Seniority* specialists you can use may depend on which person you chose to be your PCP.** You can change your PCP at any time if you want to see a plan specialist that your current PCP cannot refer you to. Later in this section, under "Choosing your PCP," we tell you how to change your PCP. If there are specific hospitals you want to use, find out whether *your PCP uses* these hospitals.

There are some services you can get on your own, without a referral

As explained above, you will get most of your routine or basic care from your PCP, and your PCP will coordinate the rest of the Covered Services you get as a plan member. If you get services from any doctor, hospital, or other health care provider without getting a referral in advance from your PCP, you may have to pay for these services yourself – even if you get the services from a Plan Provider. *But there are a few exceptions:* you can get the following services on your own, without a referral or approval in advance from your PCP. This is called "**self-refer**" when you get these services on your own. You still have to pay your co-payment for these services.

- Women's health care, which includes breast exams, mammograms (x-rays of the breast), pap tests, and pelvic exams. This care is covered without a referral from your PCP *only* if you get it from a Plan Provider.
- Flu shots and pneumonia vaccinations (as long as you get them from a Plan Provider).
- Routine vision care (Note: If you choose Harvard Vanguard Medical Associates as your provider, you can only go to their Visual Services Department for your routine eye exam and must obtain eyeglasses at Harvard Vanguard Optical Shops.)
- Emergency services, whether you get these services from Plan Providers or non-Plan Providers (see Section 3 for more information)
- Urgently needed care that you get from non-plan providers when you are temporarily outside the plan's service area. Also, urgently needed care that you get from non-plan providers when you are in the service area but, because of unusual or extraordinary circumstances, the Plan Providers are temporarily unavailable or inaccessible. (See Section 3 for more information about urgently needed care. Earlier in this section, we explain the plan's service area.)
- Renal dialysis (kidney) services that you get when you are temporarily outside the plan's service area.

Getting care when you travel or are away from the plan's service area

If you need care when you are outside the service area, your coverage is limited. The only services we cover when you are outside our service area are care for a medical emergency, urgently needed care, renal dialysis, and care that Harvard Pilgrim or a Plan Provider has approved in advance. See Section 3 for more information about care for a medical emergency and urgently needed care. If you have questions about what medical care is covered when you travel, please call Member Services at the telephone number on the cover of this booklet. See Section 6 for more information about how to fill your outpatient prescriptions when you travel or are away from the plan service area.

How to change your PCP

You may change your PCP for any reason, at any time. To change your PCP, call Member Services at the number shown on the cover of this booklet. When you call, be sure to tell Member Services if you are seeing specialists or getting other Covered Services that needed your PCP's approval (such as home health care services and durable medical equipment). Member Services will help make sure that you can continue with the specialty care and other services you have been getting when you change to a new PCP. They will also check to be sure the PCP you want to switch to is accepting new patients. Member Services will change your membership record to show the name of your new PCP, and tell you when the change to your new PCP will take effect.

What if your doctor leaves First Seniority?

Sometimes a PCP, specialist, clinic, or other Plan Provider you are using might leave the plan. If this happens, you will have to switch to another provider who is part of *First Seniority*. If your PCP leaves *First Seniority*, we will let you know, and help you switch to another PCP so that you can keep getting Covered Services.

SECTION 3 Getting care if you have a medical emergency or an urgent need for care

What is a "medical emergency"?

A "medical emergency" is when **you reasonably believe that your health is in serious danger** -- when every second counts. A medical emergency includes severe pain, a bad injury, a serious illness, or a medical condition that is quickly getting much worse.

What should you do if you have a medical emergency?

If you have a medical emergency:

- Get medical help as quickly as possible. Call 911 for help or go to the nearest emergency room. **You do <u>not</u> need to get permission first from your PCP (Primary Care Physician) or other Plan Provider.** (Section 2 tells about your PCP and Plan Providers.)
- Make sure that Harvard Pilgrim or your PCP knows about your emergency, because Harvard Pilgrim or your PCP will need to be involved in following up on your emergency care. You or someone else should call to tell your PCP about your emergency care as soon as possible, preferably within 48 hours. The number to call is located on your *First Seniority* membership card.

First Seniority or your PCP will help manage and follow up on your emergency care

Harvard Pilgrim or your PCP will talk with the doctors who are giving you emergency care to help manage and follow up on your care. When the doctors who are giving you emergency care say that your condition is stable and the medical emergency is over, what happens next is called "post-stabilization care." Your follow-up care (post-stabilization care) will be covered according to Medicare guidelines. In general, we or your PCP will try to arrange for Plan Providers to take over your care as soon as your medical condition and the circumstances allow.

What is covered if you have a medical emergency?

- You can get covered emergency medical care whenever you need it, anywhere in the world. See Section 6 for more information on how we cover outpatient prescription drugs in an emergency situation while you are out side the service area.
- **Ambulance** services are covered in situations where other means of transportation would endanger your health.

What if it wasn't really a medical emergency?

Sometimes it can be hard to know if you have a real medical emergency. For example, you might go in for emergency care -- thinking that your health is in serious danger -- and the doctor may say that it was not a medical emergency after all. If this happens to you, you are still covered for the care you got to determine what was wrong, (as long as you thought your health was in serious danger, as explained in "What is a 'medical emergency'" above). However, please note that:

- If you get any additional care after the doctor says it was *not* a medical emergency, we will pay our portion of the covered additional care **if you get it from a Plan Provider.**

- If you get any additional care from a *non-plan provider* after the doctor says it was not a medical emergency, we will usually *not* cover the additional care. There is an exception: we will pay our portion of the covered additional care from a non-plan provider if you are out of our service area, as long as the additional care you get meets the definition of "urgently needed care" that is given below.

What is "urgently needed care"? (this is different from a medical emergency)

"Urgently needed care" is **when you need medical attention right away for an unforeseen illness or injury,** and it is not reasonable given the situation for you to get medical care from your PCP or other Plan Providers. In these cases, your health is *not* in serious danger. As we explain below, how you get "urgently needed care" depends on whether you need it when you are in the plan's service area, or outside the plan's service area. Section 2 tells about the plan's service area.

What is the difference between a "medical emergency" and "urgently needed care"?

The main difference between an urgent need for care and a medical emergency is in the danger to your health. "Urgently needed care" is if you need medical help immediately, but your health is not in serious danger. A "medical emergency" is if you believe that your health is in serious danger.

Getting urgently needed care when you are <u>in</u> the plan's service area

If you have a sudden illness or injury that is not a medical emergency, and you are in the plan's service area, please call your PCP. There will always be a health professional on call to help you. Urgently needed services when you are in the plan's service area are covered when these services are provided by your PCP or by a non-plan provider if and only if your PCP is temporarily unavailable or inaccessible. Keep in mind that if you have an urgent need for care while you are in the plan's service area, we expect you to get this care from Plan Providers. In most cases, we will not pay for urgently needed care that you get from a *non-plan provider* while you are in the plan's service area.

Getting urgently needed care when you are <u>outside</u> the plan's service area

First Seniority covers urgently needed care worldwide, that you get from non-plan providers when you are outside the plan's service area. If you need urgent care while you are outside the plan's service area, we prefer that you call your PCP first, whenever possible. If you are treated for an urgent care condition while out of the service area, we prefer that you return to the service area to get follow-up care through your PCP. However, we will cover follow-up care that you get from non-plan providers outside the plan's service area as long as the care you are getting still meets the definition of "urgently needed care."

We cover renal (kidney) dialysis services that you get when you are temporarily outside the plan's service area. See Section 6 for more information on filling your prescription drugs when you are getting urgently needed care and when you are outside the plans service area.

SECTION 4 Benefits Chart – a list of the Covered Services you get as a member of *First Seniority*

What are "Covered Services"?

This section describes the medical benefits and coverage you get as a member of *First Seniority*. "**Covered Services" means the medical care, services, supplies, and equipment that are covered by *First Seniority*.** This section has a Benefits Chart that gives a list of your Covered Services and tells what you must pay for each covered service. The section that follows (Section 5) tells about **services that are *not* covered** (these are called "exclusions"). Section 5 also tells about **limitations** on certain services.

There are some conditions that apply in order to get Covered Services

Some general requirements apply to all Covered Services

The Covered Services listed in the Benefits Chart in this section are covered only when *all* requirements listed below are met:

- Services must be provided according to the Medicare coverage guidelines established by the Medicare program and according to Harvard Pilgrim's guidelines for those services that *First Seniority* provides in addition to Medicare.
- The medical care, services, supplies, and equipment that are listed, as Covered Services must be medically necessary. Certain preventive care services and screening tests are also covered. (See Section 14 for the definition of "medically necessary")
- With few exceptions, Covered Services must either be provided by Plan Providers, be approved in advance by Plan Providers, or be authorized by Harvard Pilgrim. The exceptions are care for a medical emergency, urgently needed care, and renal (kidney) dialysis you get when you are outside the plan's service area.

In addition, some Covered Services require "prior authorization" in order to be covered

Some of the Covered Services listed in the Benefits Chart in this section are covered only if your doctor or other Plan Provider gets "prior authorization" (approval in advance) from Harvard Pilgrim. Covered Services that need prior authorization are identified in the Benefits Chart.

Benefits Chart – a list of Covered Services

Benefits chart – your Covered Services	**What you must pay** when you get these Covered Services
Inpatient Services:	
Inpatient hospital care ***(This service requires Prior Authorization)*** For more information about hospital care, see Section 7. Covered Services include, but are not limited to, the following: • Semiprivate room (or a private room if medically necessary). • Meals including special diets. • Regular nursing services. • Costs of special care units (such as intensive or coronary care units). • Drugs and medications. • Lab tests. • X-rays and other radiology services. • Necessary surgical and medical supplies. • Use of appliances, such as wheelchairs. • Operating and recovery room costs. • Rehabilitation services, such as physical therapy, occupational therapy, and speech therapy services. • *Under certain conditions, the following types of transplants are covered:* corneal, kidney, pancreas, heart, liver, lung, heart/lung, bone marrow, stem cell and intestinal/multivisceral transplants. See Section 7 for more information about transplants. • Blood—including storage and administration. • Physician Services. Note: For Definitions of Hospital Day and Benefit Period, please see Section 14.	• Care in an Acute Hospital is covered to the extent Medically Necessary. There is no limit on hospital days. • Care in a Rehabilitation or Long Term Hospital is covered up to 90 days per Benefit Period minus any other covered hospital days used in the Benefit Period under *First Seniority* or Original Medicare. Medicare Lifetime Reserve Days, if any, may also be used. • If you get inpatient care at a non-plan hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at a plan hospital. Your 60 lifetime reserve days may be used for care in a Rehabilitation or Long Term Hospital

Benefits chart – your Covered Services	**What you must pay** when you get these Covered Services
Inpatient mental health care ***(This service requires Prior Authorization)*** Includes mental health care services that require a hospital stay. Note: For Definitions of Hospital Day and Benefit Period, please see Section 14.	• You pay $0 for each hospital day up to 90 days per Benefit Period, minus any other hospital days used in the same Benefit Period.
Skilled nursing facility care ***(This service requires Prior Authorization)*** For more information about skilled nursing facility care, see Section 7. Covered Services include, but are not limited to, the following: • Semiprivate room (or a private room if medically necessary). • Meals, including special diets. • Regular nursing services. • Physical therapy, occupational therapy, and speech therapy. • Drugs and medications. • Blood—including storage and administration. • Medical and surgical supplies. • Laboratory tests. • X-rays and other radiology services. • Use of appliances such as wheelchairs. • Physician services. Note: A 3-day prior hospital stay is not required.	• You pay $0 for up to 100 days per Benefit Period.

Benefits chart – your Covered Services	**What you must pay** when you get these Covered Services
Inpatient services (when the hospital or SNF days are not or are no longer covered) The following services are covered when medically necessary during an inpatient stay, even if the stay itself is not covered by *First Seniority*. For more information, see Section 7. • Physician services. • Diagnostic tests (like X-ray or lab tests). • X-ray, radium, and isotope therapy including technician materials and services. • Surgical dressings, splints, casts and other devices used to reduce fractures and dislocations. • Prosthetic devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices. • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition. • Physical therapy, speech therapy, and occupational therapy.	• You pay $0.
Home health care For more information about home health care, see Section 7. **Home Health Agency Care** ***(This service requires Prior Authorization)*** • Part-time or intermittent skilled nursing and home health aid services. • Physical therapy, occupational therapy, and speech therapy. • Medical social services. • Medical equipment and supplies. Also: • Physician Services • Durable Medical Equipment – As covered by Medicare • Portable X-rays and EKGs • Laboratory Tests	• You pay $0 for all covered home health visits. • You pay $0.
Hospice care For more information about hospice services, see Section 7. • Drugs for symptom control and pain relief, short-term respite care, and other services not otherwise covered by Medicare. • Home care. • Hospice consultation services (one time only) for a terminally ill individual who has not yet elected the hospice benefit.	• When you enroll in a Medicare-certified Hospice, your hospice services are paid by Medicare, (see Section 7 for more information about hospice services).

Benefits chart – your Covered Services	**What you must pay** when you get these Covered Services
Outpatient Services:	
Physician services, including doctor office visits • Office visits, including medical and surgical care in a physician's office or certified ambulatory surgical center. • Consultation, diagnosis, and treatment by a specialist. • Second opinion by another Plan Provider. • Outpatient hospital services.	• You pay $10 for each Primary Care Physician office visit. • You pay $10 for each Specialist office visit. • You pay $10 for Physician services at an Ambulatory Surgical Center.
Chiropractic services • Manual manipulation of the spine to correct subluxation.	• You pay $10 for each visit.
Podiatry services • Treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). • Routine foot care for members with certain medical conditions affecting the lower limbs as covered by Medicare.	• You pay $10 for each visit.
Outpatient substance abuse services Substance abuse services provided by a doctor or a qualified mental health professional as allowed under applicable state laws.	• You pay $5 for each group visit for visits 1-20 each calendar year • You pay $5 for each individual visit for visits 1-8 each calendar year. • You pay $25 for each individual visit for visits 9-20 each calendar year. • You pay 50% for each group or individual visit after the 20th visit each calendar year.

Benefits chart – your Covered Services	**What you must pay** when you get these Covered Services
Outpatient mental health care (Including Partial Hospitalization Services) Mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other mental health care professional as allowed under applicable state laws. "Partial hospitalization" is a structured program of active treatment that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	• You pay $5 for each group visit for visits 1-20 each calendar year. • You pay 5 for each individual visit for visits 1-8 each calendar year. • You pay $25 for each individual visit for visits 9-20 each calendar year. • You pay 50% for each group or individual visit after the 20th visit each calendar year. • You pay $0 for Partial Hospitalization services.
Visits for the following services have a lower copayment and are not considered part of the first 20 visits: - Medical management of Alzheimer's disease or related disorders - Detoxification - Medication management of psychiatric disorders - Psychological testing, interpretation and diagnostic consultation - Initial evaluation	• You pay $5 for each visit.

Benefits chart – your Covered Services	**What you must pay** when you get these Covered Services
Outpatient surgery ***(This service requires Prior Authorization)*** Outpatient surgery provided at an ambulatory surgical center or outpatient hospital facility.	• You pay $0 for each Medicare- covered visit or procedure.
Ambulance services • Includes ambulance services dispatched through 911, where other means of transportation could endanger your health. • Air ambulance is only covered in the following circumstances: A. For emergency air transport: 1. You require hospital care in a medical emergency, 2. No nearby facility can provide the care you need, 3. Transport by air ambulance is the only medically appropriate transportation option, and 4. You require immediate transfer from the air ambulance to an acute care hospital for admission as an inpatient. B. For human organ transplants, 1. You must be authorized to receive a human organ transplant outside the *First Seniority* service area. 2. Transport by air ambulance is the only medically appropriate transportation option. No coverage is provided for air ambulance transportation from the United States to a destination outside of the United States.	• You pay $0 for ambulance services.
Non-Emergency Transportation • Non-emergency transportation is limited to non-emergency ambulance transportation and wheel chair vans to or from a covered facility from your residence, and between covered facilities. Non-Emergency transportation is covered only when arranged by a Plan Provider or by Harvard Pilgrim <u>and</u> is medically necessary and reasonable • Non-emergency ambulance transportation is covered only when a Member is unable to get out of bed without assistance, unable to walk and unable to sit in a chair or wheelchair.	• You pay $0 for medically necessary non-emergency transportation

Benefits chart – your Covered Services	**What you must pay** when you get these Covered Services
Emergency care For more information, see Section 3. As a *First Seniority* Member you have worldwide coverage for emergency services.	• You pay $50 for each emergency room visit; you do not pay this amount if you are admitted to the hospital directly from the emergency room or within 3 days for the same condition. • If you get inpatient care at a non-plan hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at a plan hospital.
Urgently needed care For more information see Section 3. As a *First Seniority* Member you have worldwide coverage for urgently needed services.	• You pay $50 for each emergency room visit; you do not pay this amount if you are admitted to the hospital directly from the emergency room or within 3 days for the same condition. • You pay $10 for each visit to a physician's office.
Outpatient rehabilitation services • Physical therapy • Occupational therapy • Speech and language therapy • Cardiac rehabilitation therapy--covered when approved in advance (this service requires authorization) for patients who have had a heart attack in the last 12 months, have had coronary bypass surgery, and/or have stable angina pectoris.	• You pay $10 for each Medicare-covered Occupational Therapy, Physical Therapy and or Speech/Language Therapy visit. • You pay $10 for each covered Cardiac Rehabilitation Therapy visit.
Durable medical equipment and related supplies ***(This service requires Prior Authorization)*** --Including but not limited to Medicare covered items such as: wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker. (See definition of "durable medical equipment" in Section 14)	• You pay $0.

Benefits chart – your Covered Services	**What you must pay** when you get these Covered Services
Prosthetic devices and related supplies (Other than dental) which replace a body part or function. These include: • Colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). • Certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. • Also includes some coverage following cataract removal or cataract surgery (see "Vision Care" for more detail) • Harvard Pilgrim covers formulas for treatment of malabsorption caused by Chron's disease, ulcerative colitis, gastroesophogeal reflux, gastrointestinal motility, or chronic intestinal pserdo-obstruction.	• You pay $0.
• You are covered up to $350 for a wig when medically necessary and ordered by a First Seniority Provider when you have hair loss due to treatment for any form of cancer or leukemia.	• You pay for wigs in excess of $350 per wig
• Coverage is also provided for low protein foods for inherited diseases of amino acids and organic acids. This coverage is limited to $2,500 per Member per calendar year.	• You pay for costs in excess of $2,500
Diabetes self-monitoring, training and supplies *First Seniority* covers Diabetes self-monitoring, training and supplies for all people who have diabetes (insulin and non-insulin users). • Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose control solutions for checking the accuracy of test strips and monitors. • One pair per calendar year of therapeutic shoes for people with diabetes who have severe diabetic foot disease, including fitting of shoes or inserts. • Self-management training is covered under certain conditions. • *For persons at risk of diabetes:* Fasting plasma glucose tests to the extent medically necessary	• You pay $0 for test strips and lancets. • You pay $0 for blood glucose monitors including those with special features such as voice synthesizers, insulin pumps and supplies. • You pay $0 for therapeutic shoes for people with diabetes who have severe diabetic foot disease • You pay $10 for each medical nutrition therapy and self-management training visit.

Benefits chart – your Covered Services	**What you must pay** when you get these Covered Services
Medical nutrition therapy --*First Seniority* covers Medical nutrition therapy for people with diabetes, renal (kidney) disease (but not on dialysis), and after a transplant when referred by your doctor.	• You pay $10 for services in a Physician's Office. • You pay $0 for services performed in an Outpatient Department of a Hospital.
Outpatient diagnostic tests and therapeutic services and supplies • X-rays. • Outpatient radiation therapy. • Surgical supplies, such as dressings. • Supplies, such as splints and casts. • Laboratory tests. • Blood – including storage and administration.	• You pay $0.

Benefits chart – your Covered Services	**What you must pay** when you get these Covered Services
Preventive care and screening tests:	
Bone mass measurements *For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 2 years or more frequently if medically necessary:* procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	• You pay $0.
Colorectal screening *For people 50 and older, the following are covered:* • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months. • Fecal occult blood test, every 12 months. *For people at high risk of colorectal cancer, the following is covered:* • Screening colonoscopy (or screening barium enema as an alternative) every 24 months. *For people not at high risk of colorectal cancer, the following are covered:* • Screening colonoscopy every 10 years, but not within 48 months of a screening sigmoidoscopy.	• You pay $0.
Immunizations • Pneumonia vaccine (as explained in Section 2, you can get this service on your own, without a referral from your PCP as long as you get the service from a Plan Provider) • Flu shots, once a year in the fall or winter. As explained in Section 2, you can get this service on your own, without a referral from your PCP (as long as you get the service from a Plan Provider). • *If you are at high or intermediate risk of getting Hepatitis B*: Hepatitis B vaccine. • Other vaccines if you are at risk (as covered by Medicare).	• You pay $0.
Mammography screening (As explained in Section 2, you can get this service on your own, without a referral from your PCP, as long as you get it from a Plan Provider): • One baseline exam between the ages of 35 and 39. • One screening every 12 months for women age 40 and older.	• You pay $0.

Benefits chart – your Covered Services	**What you must pay** when you get these Covered Services
Pap smears, pelvic exams, and clinical breast exam (As explained in Section 2, you can get these women's health services on your own, without a referral from your PCP, as long as you get the services from a Plan Provider): • For all women, Pap smear tests, pelvic exams, and clinical breast exams	• You pay $0.
Prostate cancer screening exams ***For men over age 50, the following are covered once every 12 months:*** • Digital rectal exam. Prostate Specific Antigen (PSA) test.	• You pay $0.
Cardiovascular disease testing Blood tests, including cholesterol and other lipid or triglyceride level, for the early detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) to the extent medically necessary.	• You pay $0
Routine Physical exams Covered annually	• You pay $10 for each exam
Other services:	
Renal Dialysis (Kidney) • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Sections 2 and 3). • Inpatient dialysis treatments (if you are admitted to a hospital for special care). • Self-dialysis training (includes training for you and for the person helping you with your home dialysis treatments). • Home dialysis equipment and supplies. • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies when needed, and check your dialysis equipment and water supply).	• You pay $0.

Benefits chart – your Covered Services	**What you must pay** when you get these Covered Services
Prescription Drugs Drugs that are covered under Original Medicare (these drugs are covered for everyone with Medicare) "Drugs" includes substances that are naturally present in the body, such as blood clotting factors. • Drugs that usually are not self-administered by the patient and are injected while receiving physician services. *First Seniority* also covers some drugs that are "usually not self-adminstered" even if you inject them at home. • Drugs you take using durable medical equipment (such as nebulizers) that was authorized by Harvard Pilgrim. (See Section 14 for a definition of "durable medical equipment"). • Clotting factors you give yourself by injection if you have hemophilia. • Immunosuppressive drugs, if you have had an organ transplant that was covered by Medicare. • Injectible osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug. • Antigens. • Certain oral anti-cancer drugs and anti-nausea drugs. • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, Erythropoietin (Epogen®) or Epoetin alfa, and Darboetin Alfa (Aranesp®). • Intravenous Immune Globulin for the treatment of primary immune deficiency diseases in your home. Please see Section 6 for an explanation about the prescription drug benefit, including rules you must follow to have prescriptions covered. Section 6 also tells about drugs that are not covered by this benefit.	• You pay $0 for these specific prescription drugs covered by Medicare.

Benefits chart – your Covered Services	**What you must pay** when you get these Covered Services
Additional benefits:	
Dental services *First Seniority does not cover Dental care, except for those services listed below:* • Limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease, or services that would be covered when provided by a doctor. • Emergency dental care needed due to an injury to sound, natural teeth. All services, except for suture removal must be received within 72 hours of injury. • Coverage is provided only for the following procedures when the Member has had a serious medical condition that makes it essential that he or she be admitted to a general hospital as an inpatient or to a surgical day care unit or ambulatory surgical facility as an outpatient in order for the dental care to be performed safely: 1. Extraction of seven or more teeth; 2. Gingivectomies (including osseous surgery) of two or more gum quadrants; 3. Excision of radicular cysts involving the roots of three or more teeth; 4. Removal of one or more impacted teeth. Serious medical conditions include, but are not limited to hemophilia and heart disease. *First Seniority* provides limited coverage of dental and/or oral surgery services for members with the following serious medical conditions: • For members undergoing radiation of the jaw • Members undergoing Bone Marrow or other Human Organ Transplantations No other dental services are covered.	• You pay $10 for covered office visits. • You pay $50 for services provided in the emergency room; you do not pay this amount if you are directly admitted to the hospital from the emergency room or if you are admitted to the hospital within 3 days for the same condition.

Benefits chart – your Covered Services	**What you must pay** when you get these Covered Services
Hearing services	
• Diagnostic hearing exams.	• You pay $10 for covered office visits.
• Hearing aids	• You are covered for the cost of purchase and repair in full for the first $500 and at 80% of cost for amounts between $501 and $2,000 in a 24-month period. • There is no coverage in excess of $2,000 in a 24-month period.
Vision care	
• Outpatient physician services for eye care. • Routine eye exams are limited to one exam every 12 months. • *For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older:* glaucoma screening once per year	• You pay $10 for each eye exam.
• One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. Corrective lenses/frames and replacements needed after a cataract removal without a lens implant.	• Frames in excess of $60 per frame (not including cost of lens).
• *First Seniority* will pay up to $100 for a pair of eyeglasses every 24 months in addition to the coverage provided after cataract surgery. If you choose Harvard Vanguard Medical Associates as your provider, you can only go to their Visual Services Department for your routine eye exam and must obtain eyeglasses or post cataract glasses at Harvard Vanguard Optical shops	• For frames and lens, any cost in excess of $100.
Health and wellness education programs • Health education • Nutritional training • Smoking Cessation classes • International Fitness Club Network (IFCN) • Cholesterol Education Classes.	*First Seniority* offers discounts on a variety of health promotion services. Please call Member Services for details.

Benefits chart – your Covered Services	**What you must pay** when you get these Covered Services
Family Planning and Maternity Services Harvard Pilgrim covers family planning (including infertility treatment) and maternity care. Your PCP must refer you for infertility treatment and is responsible for getting Harvard Pilgrim approval for the referral. However, the following services may be obtained from a *First Seniority* Provider without a referral. • One consultation of expectant parents • Family planning consultation • Genetic counseling • Prenatal care within the *First Seniority* Service Area Coverage for delivery includes a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a cesarean section. (Any decision to shorten the inpatient stay for the mother and her newborn child will be made by the attending physician and the mother.) ***Referral is necessary for infertility treatment.***	• You pay $10 for services in a Physician's Office. • You pay $0 for services performed in an Outpatient Department of a Hospital.
Coronary Artery Disease (CAD) Programs These programs are designed to help Members who meet the program's defined criteria for CAD by supporting them in making lifestyle changes that can reduce cardiac risk factors. This benefit is available to Members with a history of heart disease, and is offered through two programs approved by the GIC. Members enrolled with a PCP at one of the Harvard Vanguard Medical Associates health sites can call (617) 421-2560. All other Members with PCPs in Massachusetts should contact Specialty Case Management at 1-888-888-4742, ext. 38583.	• Members are responsible for a Copayment of 10% of the cost of the program

What if you have problems getting services you believe are covered for you?

If you have any concerns or problems getting the services that you believe are covered for you as a member, we want to help. Please call Member Services at the telephone number on the cover of this booklet. You have the right to make a complaint if you have problems related to getting services or payment for services that you believe are covered for you. See Section 10 for information about making a complaint.

Can your benefits change during the year?

The Medicare program has rules about when and how we can make changes in your benefits. **We can *increase* your benefits at any time during the calendar year** (the current calendar year is the period from January 1 through December 31, 2006). Here are some examples:

- If we decide to add a new benefit, this would be an increase in your benefits (even though you might have to pay something if you use the new benefit).
- If we decide to provide more of some benefit that you already have, this would be an increase in your benefits.
- If we decide to reduce the amount of a copayment, coinsurance, or plan premium, this would also be an increase in your benefits because you would be getting the same benefits for less money.

If we decide to increase any of your benefits during the calendar year, we will let you know in writing.

The Medicare program does not allow us to *decrease* your benefits during the calendar year. We are allowed to decrease your benefits only on January 1, at the beginning of the next calendar year. The Medicare program must approve any *decreases* we make in your benefits. We will tell you in advance (in October 2006) if there are going to be any increases or decreases in your benefits for the next calendar year that begins on January 1, 2007.

At any time during the year, the Medicare program can change its national coverage. Since we cover what Original Medicare covers, we would have to make any change that the Medicare program makes. These changes could be to increase or decrease your benefits, depending on what change the Medicare program makes. In some cases, if your benefits increase, Original Medicare will pay for the benefit for the rest of the calendar year. In those cases, you will have to pay Original Medicare out-of-pocket amounts for those services. We will let you know in advance if you will have to pay Original Medicare out-of-pocket amounts for an increased benefit.

Can the prescription drugs that we cover change during the year?

The Medicare program allows us to make changes in our prescription drug formulary list at any time during the calendar year. As we explain in Section 6, the formulary is a list of drugs. A change in our drug formulary list could affect how much you have to pay when you fill a covered prescription.

SECTION 5 Medical care and services that are **NOT** covered (list of exclusions and limitations)

Introduction

The purpose of this section is to tell you about medical care and services that are not covered ("excluded") or are limited by *First Seniority*. The list below tells about these exclusions and limitations. The list describes services that are not covered under *any* conditions, and some services that are covered only under specific conditions. (The Benefits Chart in Section 4 also explains about some restrictions or limitations that apply to certain services).

If you get services that are not covered, you must pay for them yourself

We will not pay for the exclusions that are listed in this section (or elsewhere in this booklet), and neither will Original Medicare.

What services are not covered by First Seniority?

We will not pay for the exclusions that are listed in this section (or elsewhere in this booklet), and neither will Original Medicare (appeals are discussed in Sections 10 and 11).

1. Services that are not covered under Original Medicare, *unless* such services are specifically listed as covered in Section 4.
2. Services that you get from non-plan providers, *except* for care for a medical emergency and urgently needed care, renal (kidney) dialysis services that you get when you are temporarily outside the plan's service area, and care from non-plan providers that is arranged or approved by a Plan Provider. See other parts of this booklet (especially Sections 2 and 3) for information about using Plan Providers and the exceptions that apply.
3. Services that you get without a referral from your PCP, when a referral from your PCP is required for getting that service.
4. Services that you get without prior authorization, when prior authorization is required for getting that service. (Section 4 gives a definition of prior authorization and tells which services require prior authorization.)
5. Services that are not reasonable and necessary under Original Medicare plan standards unless otherwise listed as a covered service. As noted in Section 4, we provide all Covered Services according to Medicare guidelines.
6. Emergency facility services for non-authorized, routine conditions that do not appear to a reasonable person to be based on a medical emergency (See Section 3 for more information about getting care for a medical emergency).
7. Experimental or investigational medical and surgical procedures, equipment and medications, unless covered by Original Medicare or covered under an approved clinical trial. Experimental procedures and items are those items and procedures determined by Harvard Pilgrim and Original Medicare to not be generally accepted by the medical community. (See Section 7 for information about participation in clinical trails while you are a member of *First Seniority*).
8. Surgical treatment of morbid obesity *unless* determined medically necessary by a Harvard Pilgrim Medical Director or designee or if covered by Original Medicare.

9. Private room in a hospital, *unless* medically necessary.
10. Private duty nurses.
11. Personal convenience items, such as a telephone or television in your room at a hospital or skilled nursing facility.
12. Non-durable medical supplies unless (1) used in the course of diagnosis or treatment in a medical facility, (2) used in the course of authorized home health care, (3) used as a part of the functioning of a prosthetic device, or (4) used with durable medical equipment.
13. Exercise equipment.
14. Foot orthotics, except when Medically Necessary for the treatment of severe diabetic foot disease.
15. Hearing aid batteries and dentures.
16. Nursing care on a full-time basis in your home
17. Custodial care is not covered by *First Seniority unless* it is provided in conjunction with skilled nursing care and/or skilled rehabilitation services. "Custodial care" includes care that helps people with activities of daily living, like walking, getting in and out of bed, bathing, dressing, eating and using the bathroom, preparation of special diets, and supervision of medication that is usually self-administered.
18. Homemaker services.
19. Charges imposed by immediate relatives or Members of your household.
20. Meals delivered to your home.
21. Elective or voluntary enhancement procedures, services, supplies and medications including but not limited to: weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance, unless medically necessary.
22. Cosmetic surgery or procedures, *unless* it is needed because of accidental injury, disease, congenital defect, surgery or to improve the function of a malformed part of the body. Breast surgery and all stages of reconstruction for the breast on which a mastectomy was performed and, to produce a symmetrical appearance, surgery and reconstruction of the unaffected breast, is covered.
23. Routine dental care (such as cleanings, fillings, or dentures) or other dental services. Certain dental services that you get when you are in the hospital will be covered.
24. Chiropractic care is generally not covered under the plan, (with the exception of manual manipulation of the spine, as outlined in Section 4) and is limited according to Medicare guidelines.
25. Routine foot care is generally not covered under the plan and is limited according to Medicare guidelines.
26. Orthopedic shoes, *unless* they are part of a leg brace and are included in the cost of the leg brace. There is an exception: orthopedic or therapeutic shoes are covered for people with diabetic foot disease (as shown in Section 4, in the Benefits Chart under "Outpatient Medical Services").
27. Supportive devices for the feet. *There is an exception*: orthopedic or therapeutic shoes are covered for people with diabetic foot disease (as shown in Section 4, in the Benefits Chart under "Outpatient Medical Services").
28. Refractive Eye surgery, including but not limited to laser surgery, lens implantation and orthokeratology, for correction of myopia hyperopia, astigmatism. Low vision aids and services.

29. Reversal of sterilization procedures, sex change operations, non-prescription contraceptive supplies and devices, and any form of surrogacy. (Medically necessary services for infertility are covered according to Original Medicare guidelines).
30. Acupuncture.
31. Naturopaths' services.
32. Services provided to veterans in Veteran's Affairs (VA) facilities. However, in the case of emergency services received at a VA hospital, if the VA cost sharing is more than the cost sharing required under *First Seniority*, we will reimburse veterans for the difference. Members are still responsible for the *First Seniority* cost sharing amount.
33. Procedures, services, supplies, and medications until they are reviewed for safety, efficacy, and cost effectiveness and approved by Harvard Pilgrim or Medicare.
34. Hospice services in a Medicare-participating hospice are not paid for by Harvard Pilgrim, but reimbursed directly by Original Medicare when you enroll in a Medicare-certified hospice.
35. Any form of transportation, except as specifically stated in Section 4 of your Benefit Handbook.
36. Items and services which are required as a result of war, or an act of war, occurring after your Medicare effective date. This exclusion does not apply to items and services required because of an act of war which occurred prior to your entitlement to Medicare.
37. Services for which payment is required to be made by Workers' Compensation plan or an employer under state or federal law.
38. Electrolysis and biofeedback except as covered by Original Medicare.
39. Educational services (including problems of school performance) or testing for developmental, educational, or behavioral problems.
40. Vocational rehabilitation, or vocational evaluations on job adaptability, job placement or therapy to restore function for a specific occupation.
41. Routine maternity care when you are traveling outside the *First Seniority* Service Area.
42. Special equipment needed for sports or occupational purposes.
43. Services for which no charge would be made in the absence of insurance.
44. Charges for any products or services, including, but not limited to, professional fees, medical equipment, drugs and hospital or other facility charges that are related to any care that is not a covered service under this Benefit Handbook (See Section 7 for information on Participating in a Clinical Trial). This exclusion does not apply to coverage of service due to complications resulting from non-Covered Services after discharge from a hospital.
45. Home adaptations, including but not limited to chair ramps, elevators, air conditioners, dehumidifiers and air filters.

If you feel that a decision to deny coverage was in error, you may file an appeal. Please see Sections 10 and 11 for a description of your appeal rights.

Section 6 Coverage for Outpatient Prescription Drugs

This section describes the outpatient prescription drug coverage you get as a member of our Plan. There are some special rules that apply to your outpatient prescription drug coverage. This section contains:

- What a formulary is and how to use it.
- Drug Management Programs.
- How much you will pay when you fill a prescription for a covered drug.
- What an Explanation of Benefits is and how to get additional copies.
- If you have limited income and resources, you may be able to get extra help from Medicare to pay your Medicare drug plan costs so that you get your outpatient prescription drugs for little or no cost.

Using plan pharmacies to get your outpatient prescription drugs covered by us

What are network pharmacies?

With few exceptions, **you must use network pharmacies to get your outpatient prescription drugs covered.**

- **What is a "network pharmacy"?** A network pharmacy is a pharmacy where you can get your outpatient prescription drug through your prescription drug coverage. We call them "network pharmacies" because they contract with our Plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies. Once you go to one, you are not required to continue going to the same pharmacy to fill your prescription; you can go to any of our network pharmacies.
- **Participating Pharmacies**--There are over 45,000 Plan participating pharmacies in the United States, including:
    - Brooks Pharmacy
    - CVS/pharmacy
    - Eckerd
    - Harvard Vanguard Medical Associates Pharmacies (for Harvard Vanguard members only)
    - Kmart Pharmacy
    - Rite Aid
    - Star Market
    - Stop & Shop
    - Walgreens
    - Walmart
    - Many independent drug stores

    Information on participating pharmacies can be obtained from the Member Services Department by calling 1-800-421-3550. If you are hearing impaired, call our TTY machine at 1-800-421-3599 (you need special telephone equipment to use this number). Members may also locate participating pharmacies, in any area of the country, online at www.harvardpilgrim.org. *Click* Pharmacy Program.
- **What are "covered drugs"?** "Covered drugs" is the general term we use to mean all of the outpatient prescription drugs that are covered by our Plan. Covered drugs are listed in the formulary.

How do I fill a prescription at a network pharmacy?

To fill your prescription, you must show your Plan membership card at one of our network pharmacies. If you do not have your membership card with you when you fill your prescription, you may have to pay the full cost of the prescription (rather than paying just your co-payment). If this happens, you can ask us to reimburse you for our share of the cost by submitting a claim to us. To learn how to submit a paper claim, please refer to the paper claims process described at the end of this section.

The Pharmacy Directory gives you a list of Plan network pharmacies.

As a member of our Plan you will get a Pharmacy Directory, which gives you a list of our network pharmacies. You can use it to find a network pharmacy closest to you. If you don't have the Pharmacy Directory, you can get a copy from Member Services. They can also give you the most up-to-date information about changes in this Plan's pharmacy network. In addition, you can find this information on our Website.

What if a pharmacy is no longer a "network pharmacy"?

Sometimes a pharmacy might leave the plan's network. If this happens, you will have to get your prescriptions filled at another Plan network pharmacy. Please refer to your Pharmacy Directory or call Member Services to find another network pharmacy in your area. In addition, you can find this information online at www.harvardpilgrim.org.

How do I fill a prescription through Plan's network mail order pharmacy service?

You can use our network mail-order pharmacy service to fill most prescriptions. When you order prescription drugs through our network mail-order pharmacy service, you must order at least a 30-day supply, and no more than a 90-day supply of the drug. In addition to saving a trip to the pharmacy, you will pay a lower copayment for a 90-day supply of Tier 1 and Tier 2 drugs.

Generally, it takes us 14 days to process your order and ship it to you. However, sometimes your mail order may be delayed. If this occurs, please contact Member Services so that we can provide assistance obtaining a refill at a local pharmacy.

You are not required to use our mail order services to get an extended supply of maintenance medications. You can also obtain an extended supply through the plan's retail network pharmacies. You will pay the applicable tier copay for each 30-day supply though, which could cost more than if you purchased it via mail order.

Filling prescriptions outside the network

We have network pharmacies outside of the service area where you can get your drugs covered as a member of our plan. Generally, we only cover drugs filled at an out-of-network pharmacy in limited circumstances when a network pharmacy is not available. Below are some circumstances when we would cover prescriptions filled at an out-of-network pharmacy. Before you fill a prescription at an out-of-network pharmacy, please call Member Services to locate a network pharmacy. In addition, you can find this information online at www.harvardpilgrim.org.

What if I need a prescription because of a medical emergency?

We will cover prescriptions that are filled at an out-of-network pharmacy if the prescriptions are related to care for a medical emergency or urgently needed care. In this situation, you will have to pay the full cost (rather than paying just your co-payment) when you fill your prescription. You can ask us to reimburse you for our share of the cost by submitting a paper claim form. To learn how to submit a paper claim, please refer to the paper claims process described below.

Getting coverage when you travel or are away from the plan's service area

If you take a prescription drug on a regular basis and you are going on a trip, be sure to check your supply of the drug before you leave. When possible, take along all the medication you will need. You can order your prescription drugs ahead of time through our network mail order pharmacy service or through a retail network pharmacy that offers an extended supply.

If you are traveling within the US, and you become ill, lose or run out of your prescription drugs, we will cover prescriptions that are filled at an in-network pharmacy, or an out-of-network pharmacy if you follow all other coverage rules identified within this document and a network pharmacy is not available. If you use an out-of-network pharmacy, you will have to pay the full cost (rather than paying just your co-payment) when you fill your prescription. You can ask us to reimburse you for our share of the cost by submitting a claim form. To learn how to submit a paper claim, please refer to the paper claims process described below.

Prior to filling your prescription at an out-of-network pharmacy, call Member Services to find out if there is a network pharmacy in the area where you are traveling.

We cannot pay for any prescriptions that are filled by pharmacies outside the United States, even for a medical emergency.

Other times you can get your prescription covered if you go to an out-of-network pharmacy

We will cover your prescription at an out-of-network pharmacy if at least one of the following applies:

- If you are unable to get a covered drug in a timely manner within our service area because there are no network pharmacies within a reasonable driving distance that provide 24-hour service.
- If you are trying to fill a covered prescription drug that is not regularly stocked at an eligible network retail, mail order pharmacy or one of the plan's designated specialty pharmacies (these drugs include orphan drugs or other specialty pharmaceuticals).

How do I submit a paper claim?

When you go to a network pharmacy, your claim is automatically submitted to us by the pharmacy. However, if you go to an out-of-network pharmacy for one of the reasons listed above, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription.

When filing a claim, you may use the *First Seniority* Claim Reimbursement Form. To obtain a copy of this form please call the Member Services Department at **1-888-421-3550** or you may obtain a copy online at **www.harvardpilgrim.org**.

Claims for prescription drug reimbursement should be sent to Harvard Pilgrim's pharmacy benefit manager, ***MedImpact***. All claims should be sent to the following address with the information described below:

MedImpact
DMR Department
10680 Treena Street, 5th Floor
San Diego, CA 92131

Please be sure to include all the following information, and the information requested below with all claims:

- Your name
- Your *First Seniority* ID number
- Your address
- Your telephone number
- Your date of birth

Specialty pharmacies

Harvard Pilgrim has designated pharmacies that Members must use to obtain certain specialty medications. These include drugs for the treatment of infertility, hepatitis C, osteoarthritis, multiple sclerosis, rheumatoid arthritis and certain hereditary diseases. A list of the drugs that must be purchased from the specialty pharmacies may be obtained on our website at www.harvardpilgrim.org (click Pharmacy Program, then click either Infertility Pharmacy Program or Specialty Pharmacy Program). This information may also be obtained by calling our Member Services Department at 1-888-421-3550.

The Plan's specialty pharmacies have expertise in the delivery of the drugs they provide. They maintain these medications in stock at all times and can deliver them by overnight mail with the medical supplies necessary for their use. In an emergency, same day delivery can also be provided. The specialty pharmacies will give Members instruction in the administration of the drugs they provide. Additional drugs may be added to the specialty pharmacy program from time to time.

Copayments to the specialty pharmacies is the same as at other participating pharmacies. The specialty pharmacies are not part of the Plan's Mail Order Prescription Drug Program, to which different cost sharing rules apply.

Home infusion pharmacies

Plan will cover home infusion therapy if:

- Your prescription drug is on our Plan's formulary,
- You have followed all required coverage rules and our Plan has approved your prescription for home infusion therapy,
- Your prescription is written by a doctor, and
- You get your home infusion services from a Plan network pharmacy.

Please refer to your Pharmacy Directory to find a home infusion pharmacy in your area. For more information, please contact Member Services.

Long-term care pharmacies

Residents of a long-term care facility may get their prescription drugs through a long-term care pharmacy in the plan's network of long-term care pharmacies. In some cases this will be the long-term care pharmacy that contracts directly with the long-term care facility. If it is not, or for more information, please contact Member Services.

What drugs are covered by this Plan?

What is a formulary?

A formulary is a list of all the drugs we cover. We will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a network pharmacy or through our network mail order pharmacy service and other coverage rules are followed. For certain prescription drugs, we have additional requirements for coverage or limits on our coverage. These requirements and limits are described in Section 4. As a person with Medicare you are also entitled to coverage of those drugs that are covered under Medicare Part A and B. (Please see "How does your enrollment in *First Seniority* affect coverage for the drugs covered under Medicare Part A or Part B?" later in this section.)

The drugs on the formulary are selected by our Plan and the Pharmacy and Therapeutics Committee. The Pharmacy and Therapeutics Committee is an advisory group that makes recommendation for Tier placement. We select the prescription therapies believed to be a necessary part of a quality treatment program and both brand-name drugs and generic drugs are included on the formulary. A generic drug has the same active-ingredient formula as the brand-name drug. Generic drugs usually cost less than brand-name drugs and are rated by the **F**ood and **D**rug **A**dministration (FDA) to be as safe and as effective as brand-name drugs.

Not all drugs are included on the formulary. In some cases, the law prohibits coverage of certain types of drugs. (See "Drug Exclusions," later in this section, for more information about the types of drugs that cannot be covered under a Medicare Prescription Drug Plan.).

How do you find out what drugs are on the formulary?

You may call Member Services to find out if your drug is on the formulary or to request a copy of our formulary. You can also get updated information about the drugs covered by us by visiting us online at www.harvardpilgrim.org.

What are drug tiers?

Drugs on our formulary are organized into three drug tiers. Your co-payment depends on which drug tier your drugs are in. The table below shows the co-payment amount you pay for each tier when you are in your initial coverage level. (See "How much do you pay for drugs covered by this Plan?" on page 41 for more information about the initial coverage level.)

You can ask us to make an exception to your drug's tier placement. See "How Do I Request an Exception to the Formulary?" described below.

Can the formulary change?

We may add or remove drugs from the formulary during the year. Changes in the formulary may affect which drugs are covered and how much you will pay when filling your prescription. If we move a drug to a higher cost-sharing tier, and you are taking the drug affected by the change, we will notify you of the change at least 60 days before the date that the change becomes effective. If we don't notify you of the change in advance, you will get a 60 day supply of the drug when you request a refill of the drug. However, if a drug is removed from our formulary because the drug has been recalled from the market, we will not give 60-days notice before removing the drug from the formulary. Instead, we will remove the drug from our formulary immediately and notify members about the change as soon as possible.

What if your drug is not on the formulary?

Harvard Pilgrim includes nearly all FDA approved Prescription Drugs, except for a limited number of "excluded" drugs. (See "Drug Exclusions," below for more information.) If your prescription is not listed on the formulary, you should first contact Member Services to be sure it is not covered. If Member Services confirms that we do not cover your drug, you have three options:

- You can ask your doctor if you can switch to another drug that is covered by us. If you would like to give your doctor a list of covered drugs that are used to treat similar medical conditions, please contact Member Services.
- You can ask us to make an exception for us to cover your drug. See the section, "How do you request an exception to the Plan's formulary?" below for more information.
- You can pay out-of-pocket for the drug and request that the plan reimburse you by means of an exceptions request. This does not obligate the plan to reimburse you if the exception request is not approved. See Section 12 for more information on how to request an appeal.

How can you request an exception to the Plan's formulary?

You can ask us to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

- You can ask us to cover your drug even if it is not on our formulary.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, we limit the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover more.
- You can ask us to provide a higher level of coverage for your drug. For example, if your drug is usually considered a Tier 3 drug, you can ask us to cover it as a Tier 1 or Tier 2 instead. This would lower the co-payment amount you must pay for your drug. Please note, if we grant your request to cover a drug that is not on our formulary, you may not ask us to provide a higher level of coverage for the drug.

Generally, we will only approve your request for an exception if the lower-tiered drug would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

Please go to Section 12, subsection "Detailed information about how to request a coverage determination and an appeal below", to learn more about requesting an exception. In order to help us make a decision more quickly, you should include supporting medical information from your doctor when you submit your exception request.

If we approve your exception request, our approval is valid for the remainder of the plan year, so long as your doctor continues to prescribe the drug for you and it continues to be safe and effective for treating your condition. If we deny your exception request, you can appeal our decision. Please see Section 12 for more information about how to request an appeal.

Drug exclusions

By law, certain types of drugs or categories of drugs are not covered by Medicare Drug Plans. These drugs or categories of drugs are called "exclusions" and include:

- Nonprescription drugs, unless they are part of an approved step therapy (Please see "Drug Management Programs" later in this section.

- Drugs when used for anorexia, weight loss, or weight gain
- Drugs when used for cosmetic purposes including hair growth and removal
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale

In addition, a Prescription Drug Plan cannot cover a drug that is covered under Medicare Part A or Part B. See "How does your enrollment in this Plan affect coverage for drugs covered under Medicare Part A or Part B?" below.

We offer coverage on some prescription drugs not normally covered under the Medicare Part D benefit. (Drugs normally covered under the Part D benefit are sometimes called Medicare Part D drugs.) The amount you pay when you fill a prescription for these drugs does not count towards your total drug costs (that is, the amount you pay does not help you qualify for catastrophic coverage). In addition, if you are receiving extra help to pay for your prescriptions, you will not get any extra help to pay for these drugs. Please refer to the plan's formulary to find out which drugs we are offer additional coverage for or call Member Services if you have any questions.

For more information about catastrophic coverage, and out-of-pocket costs, see below.

Drug Management Programs

Utilization Management

For certain prescription drugs, we have additional requirements for coverage or limits on our coverage. These requirements and limits ensure that our members use these drugs in the most effective way and also help us control drug plan costs. A team of doctors and pharmacists developed these requirements and limits for our Plan to help us to provide quality coverage to our members. Examples of utilization management tools are described below:

- **Prior Authorization:** We require you to get prior authorization for certain drugs. This means that your physician will need to request approval from us before you fill your prescription. If they don't get approval, we may not cover the drug.
- **Quantity Limits:** For certain drugs, we limit the amount of the drug that we will cover per prescription or for a defined period of time. For example, we will provide up to 4 tablets per 30 day supply of Fosamax.
- **Step Therapy:** In some cases, we require you to first try one drug to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, we may require your doctor to prescribe Drug A first. If Drug A does not work for you, then we will cover Drug B.
- **Generic Substitution:** When there is a generic version of a brand-name drug available, our network pharmacies will automatically give you the generic version, unless your doctor has told us that you must take the brand-name drug.

You can find out if your drug is subject to these additional requirements or limits by looking in the formulary. If your drug does have these additional restrictions or limits, you can ask us to make an exception to our coverage rules. See the section, "How do I request an exception to the formulary?" described above for more information.

Drug utilization review

Drug utilization reviews are conducted for all of our members to make sure that they are getting safe and appropriate care. These reviews are especially important for members who have more than one doctor who prescribe their medications. Drug utilization reviews are conducted each time you fill a prescription and on a regular basis by reviewing our records. During these reviews, medication problems are looked for, such as:

- Possible medication errors.
- Duplicate drugs that are unnecessary because you are taking another drug to treat the same medical condition.
- Drugs that are inappropriate because of your age or gender.
- Possible harmful interactions between drugs you are taking.
- Drug allergies.
- Drug dosage errors.

If a medication problem is identified during the drug utilization review, the dispensing pharmacist will work with your doctor to correct the problem.

Medication therapy management programs

We offer medication therapy management programs at no additional cost for members who have multiple medical conditions, who are taking many prescription drugs, or who have high drug costs. These programs were developed for us by a team of pharmacists and doctors. We use these medication therapy management programs to help us provide better coverage for our members. For example, these programs help us make sure that our members are using appropriate drugs to treat their medical conditions and help us identify possible medication errors.

We offer medication therapy management programs for members that meet specific criteria. We may contact members who qualify for these programs. If we contact you, we hope you will join so that we can help you manage your medications. Remember, you do not need to pay anything extra to participate.
If you are selected to join a medication therapy management program we will send you information about the specific program.

How does your enrollment in this Plan affect coverage for the drugs covered under Medicare Part A or Part B?

As a person with Medicare, you are entitled to coverage of those drugs that are covered under Medicare Parts A and B, and the drugs that are covered in your Medicare drug plan.

Your enrollment in *First Seniority* does not affect Medicare coverage for drugs. You are entitled to all medically necessary A and B services including drugs that are covered under A and B. In addition, *First Seniority* also covers your Part D benefit.

See your *Medicare & You* Handbook for more information about drugs that are covered by Medicare Part A and Part B.

Some vaccines and drugs may be administered in your doctor's office

We cover vaccines that are medically necessary but are not already covered by Medicare Part B. In addition we cover some drugs that may be administered in your doctor's office. ("How does your enrollment in Plan affect coverage for drugs covered under Medicare Part A or Part B?" for more information.)

How much do you pay for drugs covered by this Plan?

If you qualify for extra help with your Medicare prescription drug coverage your costs for your drugs may be different than those described below. See Section 6 "Extra Help with Drug Plan Costs for People with Limited Income and Resources" and the "Low Income Subsidy Rider" for those who get extra help paying for their prescription drugs."

When you fill a prescription for a covered drug, you may pay part of the costs for your drug. The amount you pay for your drug depends on what coverage level you are in (i.e., initial coverage level, after you reach your initial coverage limit, and catastrophic level), the type of drug it is, and whether you are filling your prescription at an in-network or out-of-network pharmacy. Your drug costs for each coverage level are described below.

Initial Coverage Level

During the **initial coverage level**, we will pay part of the costs for your covered drugs and you (or others on your behalf) will pay the other part. The amount you pay when you fill a covered prescription is called the co-payment. Your co-payment will vary depending on the drug and where they prescription is filled.

Drug Tier	**Retail Co-payment (30 day supply)**	**Retail Co-payment (90 day Supply)**	**Mail-Order Co-payment (90-day supply)**
Tier 1	$10 Co-payment	$30 Co-payment	$20 Co-payment
Tier 2	$20 Co-payment	$60 Co-payment	$40 Co-payment
Tier 3	$35 Co-payment	$105 Co-payment	$105 Co-payment

Catastrophic Coverage

All Medicare Prescription Drug Plans include catastrophic coverage for people with high drug costs. In order to qualify for catastrophic coverage, you must spend $3,600 out-of-pocket for the year. You will qualify for catastrophic coverage when the total amount you have paid toward your co-payments for Part D drugs after you reach the initial coverage limit reaches $3,600. During catastrophic coverage you will pay:

Drug Tier	**Retail Co-payment (30 or 90 day supply)** **Mail Order (90 day supply)**
Tier 1	$2 Co-payment
Tier 2	$6 Co-payment
Tier 3	$12 Co-payment

As mentioned earlier we offer additional coverage on some prescription drugs not normally covered in a Medicare Drug Plan. The amount you pay when you fill a prescription for these drugs does not count towards your total out of pocket expenditure (that is, the amount you pay does not help you get catastrophic coverage).

How is your out-of-pocket cost calculated?

What type of prescription drug payments count toward your out-of-pocket costs?

The following types of payments for prescription drugs can count toward your out-of-pocket costs and help you qualify for catastrophic coverage so long as the drug is normally covered by the Plan, on the formulary (or if you get a favorable decision on a coverage determination, exception request or appeal), and it was obtained at a network pharmacy (or you have an approved claim from an out-of-network pharmacy):

- Your co-payment made on drugs normally covered in a Medicare drug plan that are:
  - Covered by the plan up to the initial coverage level
  - Not on our Plan's formulary, but were determined to count towards your out-of-pocket costs through the coverage determination, exceptions, or appeals process; and
  - Filled at an out-of-network pharmacy in accordance with our Plan's out-of-network access rules.
  - Any payments you make after the initial coverage limit for drugs.

When you have spent a total of $3,600 for these items, you will reach the catastrophic coverage level. (The amount you pay for your monthly premium **does not** count toward reaching the catastrophic coverage level.)

Purchases that will **not** count toward your out-of-pocket costs, include the following:

- Prescription drugs purchased outside the United States and its territories.
- Prescription drugs not covered by the Plan.
- Certain prescription drugs covered by *First Seniority* but not normally covered under the Medicare Part D benefit.

Who can pay for your prescription drugs, and how do these payments apply to your out-of-pocket costs?

Except for your premium payments, any payments you make for covered Part D drugs count toward your out-of-pocket costs and will help you qualify for catastrophic coverage. In addition, when the following individuals or organizations pay your prescription drug costs, these payments will count toward your out-of-pocket costs (and will help you qualify for catastrophic coverage):

- Family members or other individuals;
- Qualified State Pharmacy Assistance Programs (SPAPs);
- Medicare programs that provide extra help with prescription drug coverage; and
- Most charities or charitable organizations. Please note that if the charity is established, run or controlled by your current or former employer or union, the payments usually will not count toward your out-of-pocket costs.

Payments made by the following do **not** count toward your out-of-pocket costs:

- Group Health Plans;
- Insurance Plans and government funded health programs; and
- Third party arrangements that obligate the third party to pay for prescription costs (e.g., TRICARE, Workers Compensation).

If you have coverage from a third party that pays part or all of your out-of-pocket costs, you must disclose this information to us. An example of third party coverage would be an employer-sponsored health plan that offers prescription drug coverage.

We are responsible for keeping track of your out-of-pocket cost amount and will let you know when you have qualified for catastrophic coverage. If you or another party on your behalf has purchased drugs outside of our plan benefit, you will be responsible for submitting appropriate documentation of such purchases to *First Seniority*. In addition, every month you purchase covered prescription drugs through us, you will get an Explanation of Benefits that shows your out-of-pocket cost amount to date.

Explanation of Benefits

What is the Explanation of Benefits?

The Explanation of Benefits is a document you will get each month. It will tell you the total amount you have spent on your prescription drugs and the total amount we have paid for your drugs.

What information is included in the Explanation of Benefits?

Your Explanation of Benefits will contain the following information:

- A list of prescriptions you get during the month, as well as the amount paid for each prescription.
- Information about how to request an exception and appeal our coverage decisions.
- A description of changes to the formulary that will occur at least 60 days in the future.
- A summary of your coverage this year, including information about:
  - **Annual Deductible**-The amount you and/or others pay before you start receiving prescription coverage.
  - **Amount Paid For Prescriptions-**The amounts paid that count towards your initial coverage limit.
  - **Out-Of-Pocket Payments after you reach the initial coverage limit-**The amount you and/or others make after you reach the initial coverage limit and before you qualify for Catastrophic Coverage.
  - **Total Out-Of-Pocket Costs That Count Towards Catastrophic Coverage-**The total amount you and/or others have spent on prescription drugs that count towards your qualifying for catastrophic coverage. This total includes the amounts spent for your deductible, co-payments and payments made on covered Part D drugs after you reach the initial coverage limit. (This amount does not include payments made by your current or former employer/union, another insurance plan or policy or other excluded parties.)

What should you do if you haven't received an Explanation of Benefits or if you wish to request one?

An Explanation of Benefits is also available upon request. To obtain a copy, please contact Member Services.

How does your prescription drug coverage work if you go to a hospital or skilled nursing facility?

If you are admitted to a hospital for a Medicare-covered stay, *First Seniority* will provide your prescription drugs under your medical benefit. Once you are released from the hospital, we will provide your prescription drugs under your outpatient drug benefit.

If you are admitted to a skilled nursing facility for a Medicare-covered stay, we will arrange for any medically necessary Part A prescription drugs for the first 100 days that you are in the facility. After the first 100 days, we will cover your prescriptions as long as the skilled nursing facility's pharmacy is in our pharmacy network. Once you enter a skilled nursing facility you are entitled to a special enrollment period, during which time you will be able to leave this Plan and select another Medicare Advantage plan or original Medicare. Please see Section 13 of this document for more information about leaving this Plan.

If You Have Other Prescription Drug Coverage

We will send you a survey so that we can know what other drug coverage you have in addition to the coverage you get through this plan. CMS requires us to collect this information from you, so when you get the survey, please fill it out and send it to us. The information you provide helps us calculate how much you and others have paid for your drugs. In addition, if you lose or get additional prescription drug coverage, please call customer service to update your membership records.

If you have Medicare and Medicaid

Beginning January 1, 2006, your prescription drug coverage will change. *First Seniority,* not Medicaid, will pay for most of your prescription drugs.

If you are a member of a State Pharmacy Assistance Program (SPAP)

If you are currently enrolled in a SPAP, you may get help paying your premiums, deductibles, and/or co-payments. Please contact your SPAP to determine what benefits are available to you. Please see the Introduction for more information.

If you have a Medigap policy with prescription drug coverage

If you currently have a Medicare Supplement (Medigap) policy that includes coverage for prescription drugs, you must contact your Medigap issuer and tell them you have enrolled in our Plan. You cannot use it for out-of-pocket costs under the plan. You cannot change to another Medigap policy while you are in our plan, and if you decide to drop the policy you will not be able to get it back and in no case will you be able to get the prescription drug coverage under the policy. If you do, however, decide to keep your current Medigap policy, your Medigap issuer will remove the prescription drug coverage portion of your policy and adjust your premium. You should have received a letter in the fall of 2005 from your Medigap issuer explaining your options and how the removal of drug coverage from your Medigap policy will affect your premiums. If you do not receive this letter, please contact your Medigap issuer.

If you are a member of an employer or Union group

If you currently have prescription drug coverage through your employer or union group, you should have received information from your employer or Union group indicating whether or not your prescription drug

coverage is *creditable* (meaning whether or not it covers at least as much as Medicare's prescription drug plan coverage) and the options available to you. If you did not receive this letter, please contact your benefits administrator to find out how your current prescription drug coverage will work with this plan. In general, if you are currently employed, the prescription drug coverage you get from us will be secondary to your employer or union group coverage.

If you have a Medicare-approved drug discount card

If you are a member of a Medicare-approved drug discount card program, you may continue to use your card to get discounts on your prescription drugs until the effective date of your enrollment in this Plan or until May 15, 2006 (whichever comes first).

If you are a member of a Medicare-approved drug discount card and are getting up to $600 credit in help paying for your prescription drugs, you will be able to use any remaining credit you have towards your prescription drug purchases until the effective date of your enrollment in this Plan or until May 15, 2006 (whichever comes first).

If you have a non-Medicare approved drug discount card

If you are a member of a drug discount card program that is not Medicare-approved, please contact your drug card issuer to determine what benefits are available to you. Any amount you pay while using a discount card for drugs normally covered by Medicare prescription drug Plans and are covered by *First Seniority* can count towards your out-of-pocket expenses. Please see "How do I submit a paper claim" on page 35.

Extra help with drug plan costs for people with limited income and resources

What extra help is available?

Starting January 1, 2006, Medicare prescription drug coverage will be available to everyone with Medicare. If you have limited income and resources, you may qualify for extra help paying your prescription drug plan costs. If you qualify, you will get help paying for your drug plan's monthly premium, yearly deductible, and prescription co-payments.

Do you qualify for extra help?

People with limited income and resources may qualify for extra help. To qualify, your annual income must be below $14,355 (or $19,245 if you are married). In addition, your resources (including your savings and stocks, but not your home or car) must not exceed $11,500 (or $23,000 if you are married). The amount of extra help you get will depend on your income and resources.

Note: Amounts shown above are for 2005. If you live in Alaska or Hawaii, or pay more than half of the living expenses of dependent family members, income limits are higher. Please call Member Services to find out what the income limits are.

Some people automatically qualify for extra help and do not have to apply for it. If you answer "yes" to any of the questions below, you automatically qualify for extra help:

- Do you have Medicare and full coverage from a state Medicaid program?
- Do you get Supplemental Security Income?
- Do you get help from your state Medicaid program paying your Medicare premiums? That is, do you belong to a Medicare Savings Program, such as the Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), or Qualified Individual (QI) program?

How do you apply for extra help?

Medicare mailed letters to people who automatically qualify for extra help in May or June. If you did not automatically qualify, the Social Security Administration (SSA) sent people with certain incomes an application for this extra help. If you got this application, fill it out and send it back to SSA as soon as possible. If you did not get an application but think you may qualify, call 1-800-772-1213, visit www.socialsecurity.gov on the Web, or apply at your State Medical Assistance office. After you apply, you will receive a letter in the mail letting you know if you qualify or not and what you need to do next.

How do you get more information?

For more information on who can get extra help with prescription drug costs and how to apply, call the Social Security Administration at 1-800-772-1213, or visit www.socialsecurity.gov on the Web. TTY/TDD users should call 1-800-325-0778.

In addition, you can look at the 2006 Medicare & You Handbook, visit www.medicare.gov on the Web, or call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048.

If you have any questions about our Plan, please refer to our Member Services numbers listed on the cover and in the introduction section. Or, visit our website at www.harvardpilgrim.org, *click* HPHC Products, and then *click* First Seniority 2006.

What is the late enrollment penalty?

Under certain circumstances you will have to pay a penalty in addition to your monthly plan premium. This will occur if you do not enroll in a Medicare Drug Plan during your initial enrollment period and you do not have creditable coverage for a continuous period of 63 days or more after your initial enrollment period. Creditable prescription drug coverage is coverage that is at least as good as the standard Medicare prescription drug coverage. You pay this late enrollment penalty for as long as you have Medicare prescription drug coverage. The amount of the penalty may increase every year.

The late enrollment penalty also applies to individuals who qualify for extra help with their drug plan costs. However, Medicare helps pay for the penalty for individuals who qualify for the most help. People who qualify for the most help will pay 20% of the penalty for the first 60 months and none of the penalty afterwards.

SECTION 7 Hospital care, skilled nursing facility care, and other services (this section gives additional information about some of the Covered Services that are listed in the Benefits Chart in Section 4)

Hospital care

If you need hospital care, we will arrange Covered Services for you. Covered Services are listed in the Benefits Chart in Section 4 under the heading "Inpatient Hospital Care." We use "hospital" to mean a facility that is certified by the Medicare program and is licensed by the state to provide inpatient, outpatient, diagnostic, and therapeutic services. The term "hospital" does not include facilities that mainly provide custodial care (such as convalescent nursing homes or rest homes). By "custodial care," we mean help with bathing, dressing, using the bathroom, eating, and other activities of daily living.

See Section 14 for definition of Inpatient care.

First Seniority PCPs use particular hospitals and specialists that they refer to. Please see the section "How do you choose a PCP," on page 8 of this Benefit Handbook if there is a particular hospital or specialist that you want to use.

What is a "Benefit Period" for hospital care?

First Seniority uses Benefit Periods to determine your coverage for inpatient services during a hospital stay (generally, you are an inpatient of a hospital if you are receiving inpatient services in the hospital). A "**Benefit Period**" begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility (SNF). The Benefit Period ends when you have not been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one Benefit Period has ended, a new Benefit Period begins. There is no limit to the number of Benefit Periods you can have. (Later in this section we explain about skilled nursing facility services).

Please note that after your hospital day limits are used up, we will still pay for covered physician services and other medical services will still be covered. These services are listed in the Benefits Chart in Section 4 under the heading, "Inpatient services (when the hospital or SNF days are not or are no longer covered)."

What happens if you join or drop out of *First Seniority* during a hospital stay?

If you either join or leave *First Seniority* during an inpatient hospital stay, special rules apply to your coverage for the stay and to what you owe for this stay. If this situation applies to you, please call Member Services at the telephone number listed on the cover of this booklet. Member Services can explain how your services are covered for this stay, and what you owe to providers, if anything, for the periods of your stay when you were and were not a plan member.

What is a "hospitalist"?

A hospitalist is a physician other than your PCP or the admitting specialist who specializes in treating patients when they are in the hospital and who may coordinate your care when you are admitted to a hospital. A hospitalist is either employed by the hospital or by the group of physicians to which your PCP belongs. There is communication between your PCP and the hospitalist at the time of your admission, during your hospital stay and when you are discharged. After discharge your PCP will resume caring for you. In some cases a specialist other than a hospitalist will be the attending physician in the hospital. You should ask your PCP what arrangements have been made for his/her practice.

Skilled nursing facility care (SNF care)

If you need skilled nursing facility care, we will arrange these services for you. Covered Services are listed in the Benefits Chart in Section 4 under the heading "Skilled nursing facility care." The purpose of this subsection is to tell you more about some rules that apply to your Covered Services.

A skilled nursing facility is **a place that provides skilled nursing or skilled rehabilitation services**. It can be a separate facility, or part of a hospital or other health care facility. A **s**killed **n**ursing **f**acility is called a "SNF" for short. The term "skilled nursing facility" does not include places that mainly provide custodial care, such as convalescent nursing homes or rest homes. (By "custodial care," we mean help with bathing, dressing, using the bathroom, eating, and other activities of daily living.)

When you need specialty care in a skilled nursing facility, your care will be coordinated and provided in a *First Seniority* contracted skilled nursing facility that is affiliated with your PCP.

What is skilled nursing facility care?

"Skilled nursing facility care" means a level of care ordered by a physician that must be given or supervised by licensed health care professionals. It can be skilled nursing care, or skilled rehabilitation services, or both. Skilled nursing care includes services that require the skills of a licensed nurse to perform or supervise. Skilled rehabilitation services include physical therapy, speech therapy, and occupational therapy. Physical therapy includes exercise to improve the movement and strength of an area of the body, and training on how to use special equipment such as how to use a walker or get in and out of a wheel chair. Speech therapy includes exercise to regain and strengthen speech and/or swallowing skills. Occupational therapy helps you learn how to do usual daily activities such as eating and dressing by yourself.

To be covered, the care you get in a SNF must meet certain requirements

To be covered, you must need daily skilled nursing or skilled rehabilitation care, or both. If you do not need daily skilled care, other arrangements for care would need to be made. Note that medical services and other skilled care will still be covered when you start needing less than daily skilled care in the SNF.

Stays that provide custodial care only are not covered

"Custodial care" is care for personal needs rather than medically necessary needs. Custodial care is care that can be provided by people who do not have professional skills or training. This care includes help with walking, dressing, bathing, eating, preparation of special diets, and taking medication. Custodial care is not covered by *First Seniority* unless it is provided as other care you are getting *in addition to* daily skilled nursing care and/or skilled rehabilitation services.

There are Benefit Period limitations on coverage of skilled nursing facility care

Inpatient skilled nursing facility coverage is limited to *100* days each Benefit Period. A "**Benefit Period**" begins on the first day you go to a Medicare-covered inpatient hospital or a SNF. The Benefit Period ends when you have not been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one Benefit Period has ended, a new Benefit Period begins. There is no limit to the number of Benefit Periods you can have.

Please note that after your SNF day limits are used up, physician services and other medical services will still be covered. These services are listed in the Benefits Chart in section 4 under the heading, "Inpatient services (when the hospital or SNF days are not or are no longer covered)."

In some situations, you may be able to get care in a SNF that is not a Plan Provider

Generally, you will get your skilled nursing facility care from SNFs that are Plan Providers for *First Seniority*. However, *if certain conditions are met*, you may be able to get your skilled nursing facility care from a SNF that is not a Plan Provider. One of the conditions is that the SNF that is not a Plan Provider must be willing to accept Harvard Pilgrim's rates for payment. At your request, we may be able to arrange for you to get your skilled nursing facility care from one of the facilities listed below (in these situations, the facility is called a "Home SNF"):

- A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as the place gives skilled nursing facility care).
- A SNF where your spouse is living at the time you leave the hospital.

What happens if you join or drop out of *First Seniority* during a SNF stay?

If you either join or leave *First Seniority* during a SNF stay, special rules apply to your coverage for the stay and to what you owe for this stay. If this situation applies to you, please call Member Services at the telephone number on the cover of this booklet. Member Services can explain how your services are covered for this stay, and what you owe to Harvard Pilgrim, if anything, for the periods of your stay when you were and were not a plan member.

Home health agency care

Home health care is skilled nursing care and certain other health care services that you get in your home for the treatment of an illness or injury. Covered Services are listed in the Benefits Chart in Section 4 under the heading "Home health care." If you need home health care services, we will arrange these services for you if the requirements described below are met.

What are the requirements for getting home health agency services?

To get home health care agency benefits, you must meet all of these conditions:

1. You must be **homebound**. This means that you are normally unable to leave your home and that leaving home is a major effort. When you leave home, it must be to get medical treatment or be infrequent, for a short time. You may attend religious services. You can also get care in an adult day care program that is licensed or certified by a state or accredited to furnish adult day care services in a state.

   Occasional absences from the home for non-medical purposes, such as an occasional trip to the barber or a walk around the block or a drive, would not mean that you are not homebound if the absences are on infrequent or are of relatively short duration. The absences cannot indicate that you have the capacity to obtain the health care provided outside of your home.

   Generally speaking, you will be considered to be homebound if you have a condition due to an illness or injury that restricts your ability to leave your home except with the aid of supportive devices or if leaving home is medically contraindicated. "Supportive devices" include crutches, canes, wheelchairs, and walkers, the use of special transportation, or the assistance of another person.
2. Your doctor must decide that you need medical care in your home, and must make a plan for your care at home. Your **plan of care** describes the services you need, how often you need them, and what type of health care worker should give you these services.
3. The home health agency caring for you must be approved by the Medicare program.
4. **You must need *at least one* of the following types of skilled care:**

- Skilled nursing care on an "intermittent" (not full time) basis. Generally, this means that you must need at least one skilled nursing visit every 60 days and not require daily skilled nursing care for

more than 21 days. Skilled nursing care includes services that can only be performed by or under the supervision of a licensed nurse.

- Physical therapy, which includes exercise to regain movement and strength to an area of the body, and training on how to use special equipment or do daily activities such as how to use a walker or get in and out of a wheel chair or bathtub.
- Speech therapy, which includes exercise to regain and strengthen speech skills or to treat a swallowing problem.
- Continuing occupational therapy, which helps you learn how to do usual daily activities by yourself. For example, you might learn new ways to eat or new ways to get dressed.

Home health care can include services from a home health aide, as long as you are also getting skilled care

As long as some qualifying skilled services are *also* included, the home health care you get can include services from a home health aide. A home health aide does not have a nursing license. The home health aide provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care such as bathing, using the toilet, dressing, or carrying out the prescribed exercises. The services from a home health aide must be part of the home care of your illness or injury, and they are not covered unless you are *also* getting a covered skilled service. Home health services do not include the costs of housekeepers, food service arrangements, or full-time nursing care at home.

What are "part time" and "intermittent" home health care services?

If you meet the requirements given above for getting covered home health services, you may be eligible for "part time" or "intermittent" skilled nursing services and home health aide services.

- **"Part-time" or "Intermittent"** means your skilled nursing and home health aide services combined total less than 8 hours per day and 35 or fewer hours each week.

Hospice care for people who are terminally ill

"Hospice" is a special way of caring for people who are terminally ill, and for their families. Hospice care is physical care and counseling that is given by a team of people who are part of a Medicare-certified public agency or private company. Depending on the situation, this care may be given in the home, a hospice facility, a hospital, or a nursing home. Care from a hospice is meant to help patients make the most of the last months of life by giving comfort and relief from pain. The focus is on care, not cure.

As a member of *First Seniority*, you may receive care from any Medicare-certified hospice. Your doctor can help you arrange for your care in a hospice. If you are interested in using hospice services, you can call Member Services at the number on the cover of this booklet to get a list of the Medicare-certified hospice providers in your area, or you can call the Regional Home Health Intermediary at 1-888-896-4997. (If you are enrolled in Medicare Part B only and not entitled to Part A, you should call Member Services to get information on your hospice coverage.)

If you enroll in a Medicare-certified hospice, Original Medicare (rather than *First Seniority*) pays the hospice for the hospice services you receive. Your hospice doctor can be a Plan Provider or a non-plan provider. If you choose to enroll in a Medicare-certified hospice, you are still a plan member and continue to get the rest of your care that is unrelated to your terminal condition through *First Seniority*. If you use non-plan providers for your routine care, Original Medicare (rather than *First Seniority*) will cover your care and you will have to pay Original Medicare out-of-pocket amounts.

The Medicare program has written a booklet about "Medicare Hospice Benefits." To get a free copy call 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048), which is the national Medicare help line, or visit the Medicare website at www.medicare.gov. Section 1 tells more about how to contact the Medicare program and about the website.

Organ transplants

If you need an organ transplant, we will arrange to have your case reviewed by one of the transplant centers that is approved by Medicare (some hospitals that perform transplants are approved by Medicare, and others are not). The Medicare-approved transplant center will decide whether you are a candidate for a transplant. When all requirements are met, the following types of transplants are covered: corneal, kidney, pancreas (when performed with or after a Medicare-covered kidney transplant), liver, heart, lung, heart-lung, bone marrow, intestinal/ multivisceral and stem cell. Please be aware that the following transplants are covered only if they are performed in a Medicare-approved transplant center: heart, liver, lung, heart-lung, and intestinal/multivisceral transplants.

Participating in a clinical trial

A "clinical trial" is a way of testing new types of medical care, such as how well a new cancer drug works. Clinical trials are one of the final stages of a research process to find better ways to prevent, diagnose, or treat diseases. The trials help doctors and researchers see if a new approach works and if it is safe.

There are certain requirements for Medicare coverage of clinical trials. If you participate as a patient in a clinical trial that meets Medicare requirements, Original Medicare (and not *First Seniority*) pays the clinical trial doctors and other providers for the Covered Services you receive that are related to the clinical trial. When you are in a clinical trial, you may stay enrolled in *First Seniority* and continue to get the rest of your care that is unrelated to the clinical trial through *First Seniority*. You will have to pay the Original Medicare coinsurance for the clinical trial services.

The Medicare program has written a booklet about "Medicare and Clinical Trials." To get a free copy, call 1-800-MEDICARE (1-800-633-4227) or visit www.medicare.gov on the web. Section 1 tells more about how to contact the Medicare program and about Medicare's website.

You do *not* need to get a referral from a Plan Provider to join a clinical trial, and the clinical trial providers do *not* need to be Plan Providers. However, please be sure to **tell us before you start a clinical trial** so that we can keep track of your health care services. When you tell us about starting a clinical trial, we can let you know what services you will get from clinical trial providers.

Care in Religious Non-medical Health Care Institutions

Care in a Medicare-certified **R**eligious **N**on-medical **H**ealth **C**are **I**nstitution (RNHCI) is covered by *First Seniority* under certain conditions and only to the extent of coverage under Original Medicare. Covered services in a RNHCI are limited to non-religious aspects of care. To be eligible for covered services in a RNHCI, you must have a medical condition that would allow you to receive inpatient hospital care or extended care services, or care in a home health agency. You may get services when furnished in the home, but only items and services ordinarily furnished by home health agencies that are not RNHCIs. In addition, you must sign a legal document that says you are conscientiously opposed to the acceptance of "nonexcepted" medical treatment. ("Excepted" medical treatment is medical care or treatment that you receive involuntarily or that is required under Federal, State or local law. "Nonexcepted" medical treatment is any other medical care or treatment.) You must also get authorization (approval) in advance from *First Seniority*, or your stay in the RNHCI may not be covered.

SECTION 8 What you must pay for your Medicare health plan coverage and for the care you receive

Paying the plan premium for your coverage as a member of First Seniority

To be a member of *First Seniority*, you must continue to pay your Medicare Part B premium. If you have to pay a Medicare Part A premium (most people do not), you must continue paying that premium to be a member.

How much is your monthly plan premium and how do you pay it?

Premium bills for members enrolled through an employer will be sent directly to the employer unless employer group coverage ends. If you have any questions about your plan premiums, contact the Group Insurance Commission directly.

What happens if your employer group doesn't pay your plan premiums, or doesn't pay them on time?

Harvard Pilgrim may change your First Seniority status if your employer group does not pay your First Seniority premiums. Your membership through the employer group will be terminated and your First Seniority coverage changed to non-group status. As a non-group member, you will be responsible for the non-group premium. Harvard Pilgrim will notify you in writing of this change.

If your plan premiums are past due, we will tell you in writing when a 1-month grace period begins. If you do not pay your past-due plan premiums within the 1-month grace period, we will disenroll you. Disenrolling you ends your membership in *First Seniority.* You will then have Original Medicare coverage (Section 12 explains about disenrollment and Original Medicare coverage). Should you decide later to re-enroll in *First Seniority*, or to enroll in another plan offered by Harvard Pilgrim, you will have to pay any past-due plan premiums that you still owe from your previous enrollment in *First Seniority*.

You must pay the full cost of services that are not covered

You are personally responsible to pay for care and services that are not covered by *First Seniority*. Other sections of this booklet tell about Covered Services and the rules that apply to getting your care as a plan member. With few exceptions, you must pay for services you receive from providers who are not part of *First Seniority* unless Harvard Pilgrim has approved these services in advance. The exceptions are care for a medical emergency, urgently needed care, out-of-area renal (kidney) dialysis services. (Sections 2 and 3 explain about using Plan Providers and the exceptions that apply.)

For Covered Services that have a benefit limitation, **you must pay the full cost of any services you get after you have used up your benefit for that type of covered service.** You can call Member Services when you want to know how much of your benefit limit you have already used.

Please keep us up-to-date on any other health insurance coverage you have

Using *all* of your insurance coverage

If you have other health insurance coverage besides *First Seniority*, it is important to use this other coverage *in combination with* your coverage as a member to pay for the care you receive. This is called "coordination of benefits" because it involves *coordinating* all of the health *benefits* that are available to you. Using all of the coverage you have helps keep the cost of health care more affordable for everyone.

Let us know if you have additional insurance

You must tell us if you have any other health insurance coverage besides *First Seniority*, and let us know whenever there are any *changes* in your additional insurance coverage. The types of additional insurance you might have include the following:

- Coverage that you have from an employer's group health insurance for *employees* or *retirees*, either through yourself or your spouse.
- Coverage that you have under workers' compensation because of a job-related illness or injury, or under the Federal Black Lung Program.
- Coverage you have for an accident where no-fault insurance or liability insurance is involved.
- Coverage you have through Medicaid.
- Coverage you have through the "Tricare for Life" program (veteran's benefits).
- Coverage you have for dental insurance or prescription drugs.
- "Continuation coverage" that you have through COBRA (COBRA is a law that requires employers with 20 or more employees to let employees and their dependents keep their group health coverage for a time after they leave their group health plan under certain conditions).

Who pays first when you have additional insurance?

When you have additional insurance coverage, how we coordinate your benefits as a member of *First Seniority* with your benefits from other insurance depends on your situation. With coordination of benefits, you will often get your care as usual through *First Seniority*, and the other insurance you have will simply help pay for the care you receive. In other situations, such as for benefits that are not covered by *First Seniority*, you may get your care outside of *First Seniority.*

In general, the insurance company that pays its share of your bills *first* is called the "**primary payer**." Then the other company or companies that are involved -- called the "**secondary payers**" -- each pay their share of what is left of your bills. Often your other insurance company will settle its share of payment directly with us and you will not have to be involved. However, if payment owed to us is sent directly to you, you are required under Medicare law to give this payment to us. When you have additional health insurance, **whether we pay first or second --or at all-- depends on what type or types of additional insurance you have and the rules that apply to your situation**. Many of these rules are set by Medicare. Some of them take into account whether you have a disability or have End-Stage Renal Disease (permanent kidney failure), or how many employees are covered by an employer's group insurance.

If you have additional health insurance, please call Member Services at the phone number located on the cover of this booklet to find out which rules apply to your situation, and how payment will be handled. Also, the Medicare program has written a booklet with general information about what happens when people with Medicare have additional insurance. It's called *Medicare and Other Health Benefits: Your Guide to Who Pays First.* You can get a copy by calling 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048), or by visiting the www.medicare.gov website.

Subrogation

Subrogation is a means by which Harvard Pilgrim and other health plans recover expenses of services where a third party is legally responsible for a Member's injury or illness.

If another person or entity is, or may be, liable to pay for services related to a Member's illness or injury which may have been paid for or provided by Harvard Pilgrim, Harvard Pilgrim will be subrogated and succeed to all rights of the member to recover against such person or entity 100% of the value of the services paid for or provided by Harvard Pilgrim. Harvard Pilgrim will have the right to seek such recovery from, among others, the person or entity that caused the injury or illness, his/her liability carrier or the Member's own auto insurance carrier in cases of uninsured or underinsured motorist coverage. In the event a Member has been reimbursed by another party for medical expenses provided or paid for by Harvard Pilgrim, Harvard Pilgrim shall be entitled to recover from such member 100% of the amount the Member has received for such services from Harvard Pilgrim.

To enforce its subrogation rights under this Benefit Handbook, Harvard Pilgrim will have the right to take legal action, with or without the Member's consent, against any party to secure recovery of the value of services provided or paid for by Harvard Pilgrim for which such party is, or may be liable.

Nothing in this Agreement shall be construed to limit Harvard Pilgrim's right to utilize any remedy provided by law to enforce its rights to subrogation under this Benefit Handbook.

What should you do if you have bills from non-plan providers that you think we should pay?

As explained in Sections 2 and 3, we cover certain health care services that you get from non-plan providers. These include care for a medical emergency, urgently needed care, renal dialysis that you get when you are outside the plan's service area, and care that has been approved in advance by Harvard Pilgrim. If a non-plan provider asks you to pay for Covered Services you get in these situations, please contact us at Harvard Pilgrim Health Care, *First Seniority* Member Services, 1600 Crown Colony Drive, Quincy, MA 02169. It is best to ask a non-plan provider to bill us first, but if you have already paid for the Covered Services we will reimburse you for our share of the cost. If you received a bill for the services, you can send the bill to us for payment. We will pay your doctor for our share of the bill and will let you know what, if anything, you must pay. You will not have to pay a non-plan provider any more than what he or she would have received from you if you had been covered with Original Medicare.

SECTION 9 Your rights and responsibilities as a member of *First Seniority*

Introduction about your rights and protections

Since you have Medicare, you have certain rights to help protect you. In this first part of Section 9, we explain your Medicare rights and protections as a member of *First Seniority*. Then, after we have explained your rights, we tell you what you can do if you think you are being treated unfairly or your rights are not being respected. If you want to receive Medicare publications on your rights, you may call and request them at 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048).

Your right to be treated with fairness and respect

You have the right to be treated with dignity, respect, and fairness at all times. Harvard Pilgrim must obey laws against discrimination that protect you from unfair treatment. These laws say that we cannot discriminate against you (treat you unfairly) because of your race or color, age, religion, national origin, or any mental or physical disability you may have. If you need help with communication, such as help from a language interpreter, please call Member Services at the number shown on the cover of this booklet. Member Services can also help if you need to file a complaint about access (such as wheel chair access). You can also call the Office of Civil rights at 1-800-368-1019 or TTY/TDD 1-800-537-7697, or, call the Office for civil Rights in your area.

Your right to the privacy of your medical records and personal health information

There are federal and state laws that protect the privacy of your medical records and personal health information. We keep your personal health information private as protected under these laws. Any personal information that you give us when you enroll in this plan is protected. We will make sure that unauthorized people do not see or change your records. Generally, we must get written permission from you (or from someone you have given legal power to make decisions for you) before we can give your health information to anyone who is not providing your care or paying for your care. There are exceptions allowed or required by law, such as release of health information to government agencies that are checking on quality of care.

The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We are required to provide you with a notice that tells about these rights and explains how we protect the privacy of your health information. For example, you have the right to look at your medical records, and to get a copy of the records (there may be a fee charged for making copies). You also have the right to ask Plan Provider*s* to make additions or corrections to your medical records (if you ask Plan Provider*s* to do this, *they* will review your request and figure out whether the changes are appropriate). You have the right to know how your health information has been given out and used for non-routine purposes. If you have questions or concerns about privacy of your personal information and medical records, please call Member Services at the phone number on the cover of this booklet.

Your right to see Plan Providers, get Covered Services and get your prescriptions filled within a reasonable period of time

As explained in this booklet, you will get most or all of your care from Plan Providers, that is, from doctors and other health providers who are part of *First Seniority*. You have the right to choose a Plan Provider (we will tell you which doctors are accepting new patients). You have the right to go to a women's health specialist (such as a gynecologist) without a referral. You have the right to timely access to your providers

and to see specialists when care from a specialist is needed. You also have the right to timely access to your prescriptions at any network pharmacy. "Timely access" means that you can get appointments and services within a reasonable amount of time. Section 2 explains how to use Plan Providers to get the care and services you need. Section 3 explains your rights to get care for a medical emergency and urgently needed care.

Your right to know your treatment choices and participate in decisions about your health care

You have the right to get full information from your providers when you go for medical care, and the right to participate fully in decisions about your health care. Your providers must explain things in a way that you can understand. Your rights include knowing about all of the treatment choices that are recommended for your condition, no matter what they cost or whether they are covered by *First Seniority*. You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment, and be given the choice of refusing experimental treatments.

You have the right to receive a detailed explanation from us if you believe that a Plan Provider has denied care that you believe you are entitled to receive or care you believe you should continue to receive. In these cases, you must request an initial decision. "Initial decisions" are discussed in Section 10 and 11.

You have the right to refuse treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. If you refuse treatment, you accept responsibility for what happens as a result of refusing treatment.

Your right to use advance directives (such as a living will or a power of attorney)

You have the right to ask someone such as a family member or friend to help you with decisions about your health care. Sometimes, people become unable to make health care decisions for themselves due to accidents or serious illness. If you want to, you can use a special form to give someone you trust the legal authority to make decisions for you if you ever become unable to make decisions for yourself. You also have the right to give your doctors written instructions about how you want them to handle your medical care if you become unable to make decisions for yourself. The legal documents that you can use to give your directions in advance in these situations are called "**advance directives.**" There are different types of advance directives and different names for them. Documents called "**living will**" and "**power of attorney for health care**" are examples of advance directives.

If you decide that you want to have an advance directive, there are several ways to get this type of legal form. You can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare, such as SHINE (which stands for Serving Health Information Needs of Elders). Section 1 of this booklet tells how to contact SHINE. Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it. It is important to sign this form and keep a copy at home. You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, take a copy with you to the hospital. If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you. If you have *not* signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is *your choice* whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

If you *have* signed an advance directive, and you believe that a doctor or hospital has not followed the instructions in it, you may file a complaint with the following agencies:

In Massachusetts:

Against a hospital:

Department of Public Health
Division of Health Care Quality
Complaint Unit
10 West Street, Boston 02111-1212
Tel: (617) 753-8000

Against an individual doctor:

Board of Registration in Medicine
560 Harrison Ave., Suite G-4, Boston 02118
Tel: 1-800-377-0550

In New Hampshire:
Northeast Health Care Quality Foundation
15 Old Rollinsford Road
Dover, NH 03820
Tel: 1-800-772-0151

Your right to make complaints

You have the right to make a complaint if you have concerns or problems related to your coverage or care. "Appeals" and "grievances" are the two different types of complaints you can make. Which one you make depends on your situation. Appeals that involve your Medicare health benefits under *First Seniority* are discussed in Sections 10 and 11, Appeals and grievances that involve the *First Seniority* drug benefit are discussed in section 12.

If you make a complaint, we must treat you fairly (i.e., not discriminate against you) because you made a complaint. You have the right to get a summary of information about the appeals and grievances that members have filed against Harvard Pilgrim in the past. To get this information, call Member Services at the phone number shown on the cover of this booklet.

Your right to get information about your health care coverage and costs

This booklet tells you what medical services are covered for you as a plan member and what you have to pay. If you need more information, please call Member Services at the number shown on the cover of this booklet. You have the right to an explanation from us about any bills you may get for services not covered by *First Seniority*. We must tell you in writing why we will not pay for or allow you to get a service, and how you can file an appeal to ask us to change this decision. See Sections 10 and 11 for more information about filing an appeal.

Your right to get information about Harvard Pilgrim*, First Seniority, Plan Providers, your drug coverage and costs*

You have the right to get information from us about Harvard Pilgrim and *First Seniority*. This includes information about our financial condition, about our health care providers and their qualifications, about how *First Seniority* compares to other health plans, and about our network pharmacies. You have the right to find out from us how we pay our doctors. To get any of this information, call Member Services at the phone number shown on the cover of this booklet.

How to get more information about your rights

If you have questions or concerns about your rights and protections, please call Member Services at the number shown on the cover of this booklet. You can also get free help and information from Serving Health Information Needs of Elders, or SHINE (Section 1 tells how to contact SHINE). In addition, the Medicare program has written a booklet called *Your Medicare Rights and Protections.* To get a free copy, call 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048). You can call 24 hours a day, 7 days a week. Or you can visit the Medicare website at www.medicare.gov to order this booklet or print it directly from your computer.

What can you do if you think you have been treated unfairly or your rights are not being respected?

If you think you have been treated unfairly or your rights have not been respected, what you should do depends on your situation.

- If you think you have been treated unfairly due to your race, color, national origin, disability, age, or religion, please let us know. Or, you can call the Office for Civil Rights in your area at 1-800-368-1019 (TTY: 1-800-537-7697).
- For any other kind of concern or problem related to your Medicare rights and protections described in this section, you can call Member Services at the number shown on the cover of this booklet. You can also get help from Serving Health Information Needs of Elders, or SHINE (Section 1 tells how to contact SHINE).

What are your responsibilities as a member of First Seniority?

Along with the rights you have as a member of *First Seniority*, you also have some responsibilities. Your responsibilities include the following:

- To get familiar with your coverage and the rules you must follow to get care as a member. You can use this booklet and other information we give you to learn about your coverage, what you have to pay, and the rules you need to follow. Please call Member Services at the phone number shown on the cover of this booklet if you have any questions.
- To give your doctor and other providers the information they need to care for you, and to follow the treatment plans and instructions that you and your doctors agree upon. Be sure to ask your doctors and other providers if you have any questions.
- To act in a way that supports the care given to other patients and helps the smooth running of your doctor's office, hospitals, and other offices.
- To pay any copayments you may owe for the Covered Services you get. You must also meet your other financial responsibilities that are described in Section 8 of this booklet.
- To let us know if you have any questions, concerns, problems, or suggestions. If you do, please call Member Services at the phone number shown on the cover of this booklet.

SECTION 10 Appeals and grievances: what to do if you have complaints about your Medicare Advantage Benefits

Introduction

We encourage you to let us know right away if you have questions, concerns, or problems related to your Covered Services or the care you receive. Please call Member Services at the number on the cover of this booklet.

Note that sections 10 and 11 do not apply to Part D prescription drug benefits. See Section 12 for detailed information about how to make an appeal that involves a request for Part D drug benefits.

This section gives the rules for making complaints in different types of situations. Federal law guarantees your right to make complaints if you have concerns or problems with any part of your medical care as a plan member. The Medicare program has helped set the rules about what you need to do to make a complaint and what we are required to do when we receive a complaint. If you make a complaint, we must be fair in how we handle it. You cannot be disenrolled from *First Seniority* or penalized in any way if you make a complaint.

What are appeals and grievances?

You have the right to make a complaint if you have concerns or problems related to your coverage or care. "Appeals" and "grievances" are the two different types of complaints you can make.

- An **"appeal"** is the type of complaint you make **when you want us to reconsider and change a decision we have made about what services are covered for you or what we will pay for a service.** For example, if we refuse to cover or pay for services you think we should cover, you can file an appeal. If Harvard Pilgrim or one of our Plan Providers refuses to give you a service you think should be covered, you can file an appeal. If Harvard Pilgrim or one of our Plan Providers reduces or cuts back on services you have been receiving, you can file an appeal. If you think we are stopping your coverage of a service too soon, you can file an appeal.

- A **"grievance"** is the type of complaint you **make if you have any other type of problem with Harvard Pilgrim, *First Seniority* or one of our Plan Providers.** For example, you would file a grievance if you have a problem with things such as the quality of your care, waiting times for appointments or in the waiting room, the way your doctors or others behave, being able to reach someone by phone or get the information you need, or the cleanliness or condition of the doctor's office.

This section tells how to make complaints in different situations

The rest of this section has separate parts that tell you how to make a complaint in each of the following situations:

1. **Complaints about what we will cover for you or what we will pay for.** If Harvard Pilgrim or your doctor or another Plan Provider has refused to give you a service you think is covered, you can make an **appeal**. If we have refused to pay for a service you think is covered for you, you can make an appeal. If you have been receiving a covered service, and you think that service is being reduced or ending too soon, you can make an appeal. When you file an appeal, you are asking us to reconsider and change a decision we have made about what services we will cover for you (which includes whether we will pay for your care or how much we will pay).

2. **Complaints about your Part D prescription drug benefits that we will cover or pay for.** If Harvard Pilgrim refused to give you a Part D prescription drug benefit that you think is covered, you can request an **appeal**. If we have refused to pay for a Part D prescription drug that you have already received and you believe that it is covered, you can make an appeal. If you have been receiving a Part D prescription drug, and you think its coverage is being reduced or ending too soon, you can make an appeal. When you file an appeal, you are asking us to reconsider and change a decision we have made about what Part D prescription drug we will cover for you (which includes whether we will pay for a Part D prescription drug that you have already received, or how much we will pay). The rules that apply to appeals of drug coverage are different than the rules that apply to your health benefits. Be sure to read Section 12 so that you clearly understand the difference.

3. **Complaints if you think you are being discharged from the hospital too soon**. There is a special type of **appeal** that applies only to **hospital discharges**. If you think our coverage of your hospital stay is ending too soon, you can appeal directly and immediately to MASSPRO, which is the Quality Improvement Organization (QIO) in the state of Massachusetts, or to Northeast HealthCare Quality Foundation, which is the Quality Improvement Organization (QIO) in the state of New Hampshire The QIO is a group of health professionals *in your state* that is paid to handle this type of appeal from Medicare patients. If you make this type of appeal, your stay may be covered during the time period the QIO uses to make its determination. You must act very quickly to make this type of appeal, and it will be decided quickly.

4. **Complaints if you think your coverage for Skilled Nursing Facility (SNF), Home Health (HHA) or Comprehensive Outpatient Rehabilitation Facility (CORF) services is ending too soon.** There is another special type of **appeal** that applies only to when coverage will end for SNF, HHA or CORF services. If you think your coverage is ending too soon, you can appeal directly and immediately to MASSPRO, which is the Quality Improvement Organization in the state of Massachusetts or Northeast HealthCare Quality Foundation, which is the Quality Improvement Organization (QIO) in the state of New Hampshire. If you make this type of appeal, your stay may be covered during the time period the QIO uses to make its determination. You must act very quickly to make this type of appeal, and it will be decided quickly.

5. **Making complaints about any other type of problem you have with Harvard Pilgrim/*First Seniority* or one of our Plan Providers**. If you want to make a complaint about any type of problem other than those that are listed above, a **grievance** is the type of complaint you would make. For example, you would file a grievance to complain about problems with the quality or timeliness of your care, waiting times for appointments or in the waiting room, the way your doctors or others behave, being able to reach someone by phone or get the information you need, or the cleanliness or condition of the doctor's office. Generally, you would file the grievance with Harvard Pilgrim. But for many problems related to quality of care you get from Plan Providers, you can also complain to the QIO in your state.

PART 1. Complaints (appeals) to Harvard Pilgrim to change a decision about what we will cover or what we will pay for

This part of Section 10 explains what you can do if you have problems getting the medical care you believe we should provide. We use the word "provide" in a general way to include such things as authorizing care, paying for care, arranging for someone to provide care, or continuing to provide a medical treatment you have been getting. Problems getting the medical care you believe we should provide include the following situations:

- If you are not getting the care you want, and you believe that this care is covered by *First Seniority.*

- If we will not authorize the medical treatment your doctor or other medical provider wants to give you, and you believe that this treatment is covered by *First Seniority*.
- If you are being told that coverage for a treatment or service you have been getting will be reduced or stopped, and you feel that this could harm your health.
- If you have received care that you believe was covered by *First Seniority* while you were a member, but we have refused to pay for this care.

Six possible steps for requesting care or payment from *First Seniority*

If you are having a problem getting care or payment for care, there are six possible steps you can take to ask for the care or payment you want from us. At each step, your request is considered and a decision is made. If you are unhappy with the decision, there may be another step you can take if you want to continue requesting the care or payment.

- In Steps 1 and 2, you make your request directly to us. We review it and give you our decision.
- In Steps 3 through 6, people in organizations that are not connected to us make the decisions about your request. To keep the review independent and impartial, those who review the request and make the decision in Steps 3 through 6 are part of (or in some way connected to) the Medicare program, the Social Security Administration, or the federal court system.

The six possible steps are summarized below (they are covered in more detail in Section 11).

STEP 1: The initial decision by Harvard Pilgrim

The starting point is when we make an "initial decision" (also called an "organization determination") about your medical care or about paying for care you have already received. When we make an "initial decision," we are giving our interpretation of how the benefits and services that are covered for members of *First Seniority* apply to your specific situation. As explained in Section 11, you can ask for a "fast initial decision" if you have a request for medical care that needs to be decided more quickly than the standard time frame.

STEP 2: Appealing the initial decision by Harvard Pilgrim

If you disagree with the decision we make in Step 1, you may ask us to reconsider our decision. This is called an "**appeal**" or a "request for reconsideration." As explained in Section 11, you can ask for a "fast appeal" if your request is for medical care and it needs to be decided more quickly than the standard time frame. After reviewing your appeal, we will decide whether to stay with our original decision, or change this decision and give you some or all of the care or payment you want.

STEP 3: Review of your request by an Independent Review Organization

If we turn down part or all of your request in Step 2, we are **required** to send your request to an independent review organization that has a contract with the federal government and is not part of Harvard Pilgrim. This organization will review your request and make a decision about whether we must give you the care or payment you want.

STEP 4: Review by an Administrative Law Judge

If you are unhappy with the decision made by the organization that reviews your case in Step 3, you may ask for an **Administrative Law Judge** to consider your case and make a decision. The Administrative Law Judge works for the federal government. The dollar value of your medical care must be at least $110 to be considered in Step 4.

STEP 5: Review by a Medicare Appeals Council

If you or we are unhappy with the decision made in Step 4, either of us may be able to ask a Medicare Appeals Council to review your case**.** This Council is part of the federal department that runs the Medicare program.

STEP 6: Federal Court

If you or we are unhappy with the decision made by the Medicare Appeals Council in Step 5, either of us may be able to take your case to a Federal Court. The dollar value of your contested medical care must be at least $1,090 to go to a Federal Court.

For a more detailed explanation of all six steps outlined above, see Section 11.

PART 2. Complaints (appeals) to Harvard Pilgrim to change a decision about what Part D drugs we will cover or pay for

This part of Section 10 explains what you can do if you have problems getting the prescription drugs you believe we should provide. We use the word "provide" in a general way to include such things as authorizing prescription drugs, paying for prescription drugs, or continuing to provide a Part D prescription drug that you have been getting. Problems getting a Part D prescription drug that you believe we should provide include the following situations:

- If you are not able to get a prescription drug that you believe may be covered by *First Seniority.*
- If you have received a Part D prescription drug you believe may covered by *First Seniority* while you were a member, but we have refused to pay for the drug.
- If we will not provide or pay for a Part D prescription drug that your doctor has prescribed for you because it is not on our formulary.
- If you disagree with the amount that we require you to pay for a Part D prescription drug that your doctor has prescribed for you.
- If you are being told that coverage for a Part D prescription drug that you have been getting will be reduced or stopped.
- If there is a requirement that you try another drug before we pay for the drug your doctor prescribed, or if there is a limit on the quantity (or dose) of the drug and you disagree with the requirement or dosage limitation.

Six possible steps for requesting a Part D benefit or payment from Harvard Pilgrim

If you are having a problem getting a Part D benefit or payment for a Part D prescription drug that you have already received, there are six possible steps you can take to ask for the benefit or payment you want from us. At each step, your request is considered and a decision is made. If you are unhappy with the decision, you may be able to take another step if you want to continue requesting the benefit or payment.

- In Steps 1 and 2, you make your request directly to us. We review it and give you our decision.
- In Steps 3 through 6, people in organizations that are not connected to us make the decisions about your request. To keep the review independent and impartial, those who review the request and make the decision in Steps 3 through 6 are part of (or in some way connected to) the Medicare program or the federal court system.

The six possible steps are summarized below (they are covered in more detail in Section 12).

Step 1: The initial decision by Harvard Pilgrim

The starting point is when we make an "initial decision" (also called a "coverage determination") about your Part D prescription drug or about paying for Part D drug that you have already received. When we make an "initial decision," we are giving our interpretation of how the benefits that are covered for members of *First Seniority* apply to your specific situation. As explained in Section 12, you can ask for a "fast initial decision" if you have a request for benefits that needs to be decided more quickly than the standard time frame.

Step 2: Appealing the initial decision by Harvard Pilgrim

If you disagree with the decision we make in Step 1, you may ask us to reconsider our decision. This is called an "**appeal**" or a "request for redetermination." As explained in Section 12, you can ask for a "fast appeal" if your request for benefits needs to be decided more quickly than the standard time frame. After reviewing your appeal, we will decide whether to stay with our original decision, or change this decision and give you the benefit or payment you want.

Step 3: Review of your request by an Independent Review Organization

If we turn down your request in Step 2, you may ask an independent review organization to review our decision. The independent review organization has a contract with the federal government and is not part of Harvard Pilgrim. The independent review organization will review your request and make a decision about whether we must give you the benefit or payment you want.

Step 4: Review by an Administrative Law Judge

If you are unhappy with the decision made by the independent review organization that reviews your case in Step 3, you may ask for an Administrative Law Judge to consider your case and make a decision. The Administrative Law Judge works for the federal government. The dollar value of your contested benefit must be at least $110 to be considered in Step 4.

Step 5: Review by a Medicare Appeals Council

If you are unhappy with the decision made in Step 4, you may be able to ask the Medicare Appeals Council (MAC) to review your case. The MAC is part of the federal department that runs the Medicare program.

Step 6: Federal Court

If you are unhappy with the decision made by the MAC in Step 5, you may be able to take your case to a Federal Court. The dollar value of your contested benefit must be at least $1,090 to go to a Federal Court. For a more detailed explanation of all six steps outlined above, see Section 12.

PART 3. Complaints (appeals) if you think you are being discharged from the hospital too soon

When you are hospitalized, you have the right to get all the hospital care covered by *First Seniority* that is necessary to diagnose and treat your illness or injury. The day you leave the hospital (your "discharge date") is based on when your stay in the hospital is no longer medically necessary. This part of Section 10 explains what to do if you believe that you are being discharged too soon.

Information you should receive during your hospital stay

When you are admitted to the hospital, someone at the hospital should give you a notice called the *Important Message from Medicare*. This notice explains:

- Your right to get all medically necessary hospital services covered.
- Your right to know about any decisions that the hospital, your doctor, or anyone else makes about your hospital stay and who will pay for it.
- That your doctor or the hospital may arrange for services you will need after you leave the hospital.
- Your right to appeal a discharge decision.

Review of your hospital discharge by the Quality Improvement Organization

If you think that you are being discharged too soon, you must ask your health plan to give you a notice called the *Notice of Discharge & Medicare Appeal Rights.* This notice will tell you:

- Why you are being discharged.
- The date that we will stop covering your hospital stay (stop paying our share of your hospital costs).
- What you can do it you think you are being discharged too soon.
- Who to contact for help.

You (or someone you authorize) may be asked to sign and date this document, to show that you received the notice. Signing the notice does not mean that you agree that you are ready to leave the hospital – it only means that you received the notice. If you do not get the notice after you have said that you think you are being discharged too soon, be sure to ask for it immediately.

You have the right by law to ask for a review of your discharge date. As explained in the *Notice of Discharge & Medicare Appeal Rights*, if you act quickly, you can ask an outside agency called the Quality Improvement Organization to review whether your discharge is medically appropriate.

What is the "Quality Improvement Organization"?

"QIO" stands for **Q**uality **I**mprovement **O**rganization. The QIO is a group of doctors and other health care experts paid by the federal government to check on and help improve the care given to Medicare patients. They are not part of Harvard Pilgrim or your hospital. There is one QIO in each state. QIOs have different names, depending on which state they are in. In Massachusetts, the QIO is called MASSPRO. In New Hampshire, the QIO is called Northeast HealthCare Quality Foundation. The doctors and other health experts in MASSPRO review certain types of complaints made by Medicare patients. These include complaints about quality of care and complaints from Medicare patients who think the coverage for their hospital stay is ending too soon. Section 1 tells how to contact the QIO.

Getting a QIO review of your hospital discharge

If you want to have your discharge reviewed, you must act quickly to contact the QIO. The *Notice of Discharge & Medicare Appeal Rights* gives the name and telephone number of your QIO and tells you what you must do.

- You must ask the QIO for a **"fast review"** of whether you are ready to leave the hospital. This "fast review" is also called a "fast appeal" because you are appealing the discharge date that has been set for you.

- You must be sure that you have made your request to the QIO **no later than noon** on the first working day after you are given written notice that you are being discharged from the hospital. This deadline is very important. If you meet this deadline, you are allowed to stay in the hospital past your discharge date without paying for it yourself, while you wait to get the decision from the QIO (see below).

If the QIO reviews your discharge, it will first look at your medical information. Then it will give an opinion about whether it is medically appropriate for you to be discharged on the date that has been set for you. The QIO will make this decision within one full working day after it has received your request and all of the medical information it needs to make a decision.

- If the QIO decides that your discharge date was medically appropriate, you will not be responsible for paying the hospital charges until noon of the calendar day after the QIO gives you its decision.
- If the QIO agrees with you, then we will continue to cover your hospital stay for as long as medically necessary.

What if you do not ask the QIO for a review by the deadline?

You still have another option: asking Harvard Pilgrim *for a "fast appeal" of your discharge*

If you do not ask the QIO for a "fast review" ("fast appeal") of your discharge by the deadline, you can ask us for a "fast appeal" of your discharge. How to ask us for a fast appeal is covered briefly in the first part of this section and in more detail in Section 11.

If you ask us for a fast appeal of your discharge and you stay in the hospital past your discharge date, you run the risk of having to pay for the hospital care you receive past your discharge date. Whether you have to pay or not depends on the decision we make.

- If we decide, based on the fast appeal, that you need to stay in the hospital, we will continue to cover your hospital care for as long as medically necessary.
- If we decide that you should not have stayed in the hospital beyond your discharge date, then we will not cover any hospital care you received if you stayed in the hospital after the discharge date. (Unless the independent review organization (IRE) overturns our decision.)

You may have to pay if you stay past your discharge date

If you stay in the hospital past noon on the date of discharge date and do not ask for immediate QIO review, you may be financially responsible for the cost of many of the services you receive. However, you can appeal any bills for hospital care you receive, using Step 1 of the appeals process described in Section 11.

PART 4. Complaints (appeals) if you think your coverage for SNF, home health or comprehensive outpatient rehabilitation facility services is ending too soon.

When you are a patient in a SNF, home health agency (HHA), or comprehensive outpatient rehabilitation facility (CORF), you have the right to get all the SNF, HHA or CORF care covered by *First Seniority* that is necessary to diagnose and treat your illness or injury. The day we end your SNF, HHA or CORF coverage is based on when your stay is no longer medically necessary. This part of Section 10 explains what to do if you believe that your coverage is ending too soon.

Information you will receive during your SNF, HHA or CORF stay

If we decide to end our coverage for your SNF, HHA, or CORF services, you will get written notice either from us or your provider at least 2 calendar days before your coverage ends. You (or someone you authorize) will be asked to sign and date this document, to show that you received the notice. Signing the notice does not mean that you agree that coverage should end – it only means that you received the notice.

How to appeal your coverage to the Quality Improvement Organization

You have the right by law to ask for an appeal of our termination of your coverage. As will be explained in the notice you get from us or your provider, you can ask the Quality Improvement Organization (the "QIO") to do an independent review of whether our terminating your coverage is medically appropriate.

How soon you have to ask the QIO to review your coverage?

If you want to have the termination of your coverage appealed, you must act quickly to contact the QIO. The written notice you got from us or your provider gives the name and telephone number of your QIO and tells you what you must do.

- If you get the notice 2 days before your coverage ends, you must be sure to make your request **no later than noon** of the day after you get the notice.
- If you get the notice and you have more than 2 days before your coverage ends, then you must make your request **no later than noon** the day before the date that your Medicare coverage ends.

What will happen during the review?

If the QIO reviews your case, the QIO will ask for your opinion about why you believe the services should continue. You do not have to prepare anything in writing, but you may do so if you wish. The QIO will also look at your medical information, talk to your doctor, and review other information that we have given to the QIO. You and the QIO will each get a copy of our explanation about why your services should not continue.

After reviewing all the information, the QIO will give an opinion about whether it is medically appropriate for your coverage to be terminated on the date that has been set for you. The QIO will make this decision within one full day after it receives the information it needs to make a decision.

What happens if the QIO decides in your favor?

If the QIO agrees with you, then we will continue to cover your SNF, HHA or CORF services for as long as medically necessary.

What happens if the QIO denies your request?

If the QIO decides that our decision to terminate coverage was medically appropriate, you will be responsible for paying the SNF, HHA or CORF charges after the termination date on the advance notice you got from us or your provider. Neither Original Medicare nor Harvard Pilgrim will pay for these services. If you stop receiving services on or before the date given on the notice, you can avoid any financial liability.

What if you do not ask the QIO for a review in time?

You still have another option: asking Harvard Pilgrim for a "fast appeal" of your discharge

If you do not ask the QIO for a "fast appeal" of your discharge by the deadline, you can ask us for a "fast appeal" of your discharge. How to ask us for a fast appeal is covered briefly in the first part of this section and in more detail in Section 11.

If you ask us for a fast appeal of your termination and you continue getting services from the SNF, HHA, or CORF, you run the risk of having to pay for the care you receive past your termination date. Whether you have to pay or not depends on the decision we make.

- If we decide, based on the fast appeal, that you need to continue to get your services covered, then we will continue to cover your care for as long as medically necessary.
- If we decide that you should not have continued getting coverage for your care, then we will **not** cover any of the care you received if you stayed after the termination date.

You may have to pay if you stay past your discharge date

If you do not ask the QIO by noon after the day you are given written notice that we will be terminating coverage for your SNF, HHA or CORF services, and if you stay in the SNF, HHA or CORF after this date, you run the risk of having to pay for the SNF, HHA or CORF care you receive on and after this date. However, you can appeal any bills for SNF, HHA or CORF care you receive using Step 1 of the appeals process described in Section 11.

PART 5. Complaints (grievances) about any other type of problem you have with Harvard Pilgrim, First Seniority or one of our Plan Providers

This last part of Section 10 explains how to make complaints about any *other* type of problem that has not already been discussed earlier in this section. (The problems that have already been discussed are problems related to coverage or payment for care, problems about being discharged from the hospital too soon, and problems about coverage for SNF, HHA, or CORF services ending to soon.)

What is included in "all other types of problems"?

Here are some examples of problems that are included in this category of "all other types of problems":

- Problems with the quality of the medical care you receive, including quality of care during a hospital stay.
- If you feel that you are being encouraged to leave (disenroll from) *First Seniority*.
- Problems with the customer service you receive.
- Problems with how long you have to spend waiting on the phone, in the waiting room, or in the exam room.
- Problems with getting appointments when you need them, or having to wait a long time for an appointment.
- Disrespectful or rude behavior by doctors, nurses, receptionists, or other staff.
- Cleanliness or condition of doctor's offices, clinics, or hospitals.

If you have one of these types of problems and want to make a complaint, it is called "filing a grievance." In addition, you have the right to ask for a "fast grievance" if you disagree with our decision to not give you a "fast appeal" or if we take an extension on our initial decision or appeal. See below for more detail.

Filing a grievance with *First Seniority*

If you have a complaint, we encourage you to first call Member Services at the number shown on the cover of this booklet. We will try to resolve any complaint that you might have over the phone. If you request a written response to your phone complaint, we will respond in writing to you. If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. We call this the Harvard Pilgrim grievance procedure. To use the formal grievance procedure, send your grievance in writing to Member Services. We must notify you of our decision about your grievance as quickly as your case requires based on your health status, but no later than 30 calendar days after receiving your complaint. We may extend the timeframe by up to 14 calendar days if you request the extension, or if we justify a need for additional information and the delay is in your best interest.

For quality of care problems, you may also complain to the QIO

If you are concerned about the quality of care you received, including care during a hospital stay, you can also complain to an independent organization called the QIO. See Section 1 for more information about the QIO.

SECTION 11 Detailed information about how to make an appeal that involves your Medicare Advantage Benefits

What is the purpose of this section?

The purpose of this section is to give you more information about a topic that is summarized briefly in the previous section of this booklet (Section 10). Section 10 outlines the six possible steps in the appeals process for making complaints about your coverage or payment for your care. This section goes through the same six steps in more detail. Since Section 10 also gives general information about making complaints, and discusses how to deal with other types of problems besides problems with coverage or payment for care, **you should read Section 10 before you read this section.**

Note that Section 11 does not apply to Part D prescription drug benefits. See Section 12 for detailed information about how to make an appeal that involves a request for Part D drug benefits.

A note about terminology. In this Section, we tend to use simpler language instead of certain legal language, including terms that appear in the government regulations for the appeals process. For example, we generally say "initial decision" instead of "initial organization determination," and we generally use the word "fast" rather than "expedited" when referring to decisions that are made more quickly than the standard time frame. Instead of saying "adverse decision," we may say "deny your request," or "turn down your appeal." We use "independent review organization" rather than "independent review entity."

What are "complaints about your coverage or payment for your care"?

Complaints about your coverage or payment for your care are complaints you may have if you are not getting medical benefits and services you believe are covered for you as a plan member. This includes payment for care received while a member of *First Seniority*. Complaints about your coverage or payment for your care include complaints about the following situations:

- If you are not getting the care you want, and you believe that this care is covered by *First Seniority*
- If we will not authorize the medical treatment your doctor or other medical provider wants to give you, and you believe that this treatment is covered by *First Seniority*
- If you are being told that coverage for a treatment or service you have been getting will be reduced or stopped, and you feel that this could harm your health
- If you have received care that you believe is covered by *First Seniority*, but we have refused to pay for this care because we say it is not covered

How does the appeals process work?

The six possible steps you can take to make complaints related to your coverage or payment for your care are described below. Here are a few things to keep in mind as you read the description of these steps in the appeals process:

- **Moving from one step to the next**. At each step, your request for care or payment is considered and a decision is made. The decision may be partly or completely in your favor (giving you some or all of what you have asked for), or it may be completely denied (turned down). If you are unhappy with the decision, there may be another step you can take to get further review of your request. Whether you are able to take the next step may depend on the dollar value of the medical care involved or on other factors.

- **"Initial decision" vs. "making an appeal."** Step 1 deals with the starting point for the appeals process. The decision made in Step 1 is called an "initial decision" or "organization determination." If you continue with your complaint by going on to Step 2, it is called making an "appeal" or a "request for reconsideration" of our initial decision because you are "appealing" for a change in the initial decision that was made in Step 1. Step 2, and all of the remaining possible steps, also involve *appealing* a decision.
- **Who makes the decision at each step**. In Step 1, you make your request for coverage of care or payment for care directly to us. We review this request, then make an initial decision. If our initial decision turns down your request, you can go on to Step 2, where you "appeal" this initial decision (asking us to reconsider). **After Step 2, your appeal goes outside of Harvard Pilgrim, where people who are not connected to us conduct the review and make the decision.** To help ensure a fair, impartial decision, those who make the decision about your appeal in Steps 3-6 are part of (or in some way connected to) the Medicare program, the Social Security Administration, or the federal court system.

STEP 1: Harvard Pilgrim makes an "initial decision" about your medical care, or about paying for care you have already received

What is an "initial decision"?

The "initial decision" made by Harvard Pilgrim is the starting point for dealing with requests you may have about your coverage or payment for your care. With this decision, we inform you whether we will provide the medical care or service you request, or pay for a service you have already received. (This "initial decision" is sometimes called an "organization determination.") If our initial decision is to deny your request (this is sometimes called an "adverse initial decision"), you can "appeal" the decision by going on to Step 2 (see below). You may also go on to Step 2 if we fail to make a timely "initial decision" on your request.

- If you ask us to pay for medical care you have already received, this is a request for an "initial decision" about payment for your care. You can call us at **1-800-421-3550** to get help in making this request.
- If you ask for a specific type of medical treatment from your doctor or other medical provider, this is a request for an "initial decision" about whether the treatment you want is covered by *First Seniority*. Depending on the situation, your doctor or other medical provider may make this decision on behalf of Harvard Pilgrim, or may ask us whether we will authorize the treatment. You may want to ask us for an initial decision without involving your doctor. You can call us at **1-800-421-3550**, (for TTY call **1-800-421-3599**) to ask for an initial decision.

When we make an "initial decision," we are giving our interpretation of how the benefits and services that are covered for members of *First Seniority* apply to your specific situation. This booklet and any amendments you may receive describe the benefits and services covered by *First Seniority*, including any limitations that may apply to these services. This booklet also lists exclusions (services that are "not covered" by *First Seniority*).

Who may ask for an "initial decision" about your medical care or payment?

You can ask us for an initial decision yourself, or you can name someone to do it for you. This person you name would be your *authorized representative*. You can name a relative, friend, advocate, doctor, or someone else to act for you. Some other persons may already be authorized under State law to act for you. If you want someone to act for you, then you and the person you want to act for you must sign and date a statement that gives this person legal permission to act as your authorized representative. This statement must be sent to us at Harvard Pilgrim

Health Care, *First Seniority* Member Services, 1600 Crown Colony Drive, Quincy, MA 02169. You can call us at **1-800-421-3550**, (for TTY call **1-800-421-3599**) to learn how to name your authorized representative.

You also have the right to have an attorney ask for an initial decision on your behalf. You can contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. You may want to contact Medicare Advocacy Project at 1-800-323-3205 (for TTY call 1-617-371-1228).

"Standard decisions" vs. "fast decisions" about medical care

Do you have a request for medical care that needs to be decided more quickly than the standard time frame?

A decision about whether we will cover medical care can be a "standard decision" that is made within the standard time frame (typically within 14 days, see below), or it can be a "fast decision" that is made more quickly (typically within 72 hours). A fast decision is sometimes called a 72-hour decision or an "expedited organization determination."

You can ask for a fast decision **only** if you or any doctor believe that waiting for a standard decision could seriously harm your health or your ability to function. (Fast decisions apply only to requests for medical care. You cannot get a fast decision on requests for payment for care you have already received.)

Asking for a standard decision

To ask for a standard decision about medical care or payment for care, you or your authorized representative should mail or deliver a request in writing to the following address: Harvard Pilgrim Health Care, *First Seniority* Member Services, 1600 Crown Colony Drive, Quincy, MA 02169.

Asking for a fast decision

You, any doctor, or your authorized representative can ask us to give a "fast" decision (rather than a "standard" decision) about medical care by calling us at **1-800-421-3550** (for TTY, call **1-800-421-3599**). Or, you can deliver a written request to Harvard Pilgrim Health Care, *First Seniority* Member Services, 1600 Crown Colony Drive, Quincy, MA 02169, or fax it to 1-617-509-3086. Be sure to ask for a "fast" or "72-hour" review. To deliver a request outside of regular weekday business hours, please fax your request to 1-617-509-3086.

- If **any** doctor asks for a fast decision for you, or supports you in asking for one, and the doctor indicates that waiting for a standard decision could seriously harm your health or your ability to function, we will automatically give you a fast decision.
- If you ask for a fast initial decision without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast initial decision, we will send you a letter informing you that if you get a doctor's support for a "fast" review, we will automatically give you a fast decision. The letter will also tell you how to file a "grievance" if you disagree with our decision to deny your request for a fast review. It will also tell you about your right to ask for a "fast grievance." If we deny your request for a fast initial decision, we will instead give you a standard decision (typically within 14 calendar days; see below).

What happens when you request an "initial decision"?

What happens, including how soon we must decide depends on the type of decision.

1. For a decision about payment for care you already received.

We have 30 calendar days to make a decision after we have received your request. However, if we need more information, we can take up to 30 more days. You will be told in writing when we make a decision. If we do not approve your request for payment, we must tell you why, and tell you how you can appeal this decision. If

you have not received an answer from us within 60 calendar days of your request for payment, then the failure to receive an answer is the same as being told that your request was not approved. You may then appeal this decision. (An appeal is also called a reconsideration.) Step 2 tells how to file this appeal.

2. For a standard initial decision about medical care.
We have up to 14 calendar days to make a decision after we have received your request, but we will make it sooner if your health condition requires. However, we are allowed to take up to an additional 14 calendar days to make a decision if you request the additional time, or if we need more time to gather information that may benefit you. For example, we may need more time to get information that would help us approve your request for medical care (such as medical records). When we take additional days, we will notify you in writing of this extension. If you feel that we should not take additional days, you can make a specific type of complaint called a "grievance." Section 10 of this booklet tells how to file a grievance.

We will tell you in writing of our initial decision concerning the medical care you have requested. You will receive this notification when we make our decision, under the time frame explained above. If we do not approve your request, we must explain why, and tell you of your right to appeal our decision. Step 2 tells how to file this appeal.

If you have not received an answer from us within 14 calendar days of your request for the initial decision, the failure to receive an answer is the same as being told that your request was not approved, and you have the right to appeal. Step 2 tells how to file this appeal. If we tell you that we extended the number of days needed for a decision and you have not received an answer from us by the end of the extension period, the failure to receive an answer is the same as being told that your request was not approved, and you do have the right to appeal.

3. For a fast initial decision about medical care.
If you receive a "fast" review, we will give you our decision about your medical care within 72 hours after you or your doctor ask for a "fast" review -- sooner if your health requires. However, we are allowed to take up to 14 more calendar days to make this decision if we find that some information is missing which may benefit you, or if you need more time to prepare for this review. If you feel that we should not take any additional days, you can make a specific type of complaint called a "grievance." Section 10 of this booklet tells how to file a grievance.

We will tell you our decision by phone as soon as we make the decision. Within three calendar days after we tell you of our decision in person or by phone, we will send you a letter that explains the decision. If we do not tell you about our decision within 72 hours (or by the end of any extended time period), this is the same as denying your request. If we deny your request for a fast decision, you may file a grievance. Section 10 of this booklet tells how to file a grievance.

What happens next if we decide completely in your favor?

If we make an "initial decision" that is completely in your favor, what happens next depends on the situation.

1. For a decision about payment for care you already received.

We must pay within 30 calendar days of your request for payment, unless your request has errors or missing information. Then, we must pay within 60 calendar days.

2. For a standard decision about medical care.

We must authorize or provide you with the care you have requested as quickly as your health requires, but no later than 14 calendar days after we received the request you made for the initial decision. If we extended the time needed to make the decision, we will approve or provide your medical care when we make our decision.

3. For a fast decision about medical care.

We must authorize or provide you with the medical care you have requested within 72 hours of receiving your request. If your health would be affected by waiting this long, we must provide it sooner.

What happens next if we deny your request?

If we deny your request, we may decide *completely* or only *partly* against you. For example, if we deny your request for payment for care that you have already received, we may say that we will pay nothing or only part of the amount you requested. In denying a request for medical care, we might decide not to approve any of the care you want, or only some of the care you want. If any initial decision does not give you *all* that you requested, you have the right to ask us to reconsider the decision. (See Step 2).

STEP 2: If we deny part or all of your request in Step 1, you may ask us to reconsider our decision. This is called an "appeal" *or* "request for reconsideration."

Please call us at **1-800-421-3550**, (for TTY call **1-800-421-3599**) if you need help in filing your appeal. You may ask us to reconsider the initial decision we made in Step 1, even if only part of our decision is not what you requested. When we receive your request to reconsider the initial decision, we give the request to different people than those who were involved in making the initial decision. This helps ensure that we will give your request a fresh look.

How you make your appeal depends on whether it is about payment for care you already received, or about authorizing medical care. If your appeal concerns a decision we made about authorizing medical care, then you and/or your doctor will first need to decide whether you need a "fast" appeal. The procedures for deciding on a "standard" or a "fast" *appeal* are the same as those described for a "standard" or "fast" *initial decision* in Step 1. Please see the discussion in Step 1 under "Do you have a request for medical care that needs to be decided more quickly than the standard time frame?" and "Asking for a fast decision."

Getting information to support your appeal

We must gather all the information we need to make a decision about your appeal. If we need your assistance in gathering this information, we will contact you. You have the right to obtain and include additional information as part of your appeal. For example, you may already have documents related to the issue, or you may want to get the doctor's records or the doctor's opinion to help support your request. You may need to give the doctor a written request to get information.

You can give us your additional information in any of the following ways:

- In writing, to Harvard Pilgrim Health Care, *First Seniority* Member Services, 1600 Crown Colony Drive, Quincy, MA 02169
- By fax, at 1-617-509-3086.
- By telephone -- if it is a "fast" appeal -- at **1-800-421-3550**.
- In person, at Harvard Pilgrim Health Care, *First Seniority* Member Services, 1600 Crown Colony Drive, Quincy, MA 02169

You also have the right to ask us for a copy of information regarding your appeal. You can call or write us at **1-800-421-3550**, (for TTY call **1-800-421-3599**); Harvard Pilgrim, 1600 Crown Colony Drive, Quincy MA 02169.

How do you file your appeal of the initial decision?

The rules about who may file an appeal in Step 2 are the same as the rules about who may ask for an "initial decision" in Step 1. Follow the instructions in Step 1 under "Who may ask for an 'initial decision'" about medical care or payment?"

Either you, someone you appoint, or your provider may file this appeal.

However, providers who do not have a contract with Harvard Pilgrim must sign a "waiver of payment" statement that says that they will not ask you to pay for the medical service under review, regardless of the outcome of the appeal.

How soon must you file your appeal?

The appeal should be given to us in writing at Harvard Pilgrim Health Care, *First Seniority* Member Services, 1600 Crown Colony Drive, Quincy, MA 02169, within 60 calendar days after we notify you of the initial decision from Step 1. We can give you more time if you have a good reason for missing the deadline.

You may also send your appeal to your Social Security Administration office. Please note that sending your appeal to this office instead of to us will cause a delay when we begin the appeal, since this office must forward your appeal request to us.

What if you want a "fast" appeal?

The rules about asking for a "fast" appeal in Step 2 are the same as the rules about asking for a "fast" initial decision in Step 1. If you want to ask for a "fast" appeal in Step 2, please follow the instructions in Step 1 under "Asking for a fast decision."

How soon must we decide on your appeal?

How quickly we decide on your appeal depends on the type of appeal:

1. *For a decision about payment for care you already received.*

After we receive your appeal, we have 60 calendar days to make a decision. If we do not decide within 60 calendar days, your appeal *automatically* goes to Step 3, where an independent organization will review your case.

2. *For a standard decision about medical care.*

After we receive your appeal, we have up to 30 calendar days to make a decision, but will make it sooner if your health condition requires. However, if you request it, or if we find that some information is missing which can help you, we can take up to 14 more calendar days to make our decision. If we do not tell you our decision within 30 calendar days (or by the end of the extended time period), your request will *automatically* go to Step 3, where an independent organization will review your case.

3. *For a fast decision about medical care.*

After we receive your appeal, we have up to 72 hours to make a decision, but will make it sooner if your health requires. However, if you request it, or if we find that some information is missing which can help you, we can take up to 14 more calendar days to make our decision. If we do not tell you our decision within 72 hours (or by the end of the extended time period), your request will automatically go to Step 3, where an independent organization will review your case.

What happens next if we decide completely in your favor?

1. *For a decision about payment for care you already received.*

   We must pay within 60-calendar days of the day we received your request for us to reconsider our initial decision. If we decide only partially in your favor, your appeal automatically goes to Step 3, where an independent organization will review your case.

2. *For a standard decision about medical care.*

   We must authorize or provide you with the care you have asked for as quickly as your health requires, but no later than 30 calendar days after we received your appeal. If we extend the time needed to decide your appeal, we will authorize or provide your medical care when we make our decision.

3. *For a fast decision about medical care.*

   We must authorize or provide you with the care you have asked for within 72 hours of receiving your appeal -- or sooner, if your health would be affected by waiting this long. If we extended the time needed to decide your appeal, we will authorize or provide your medical care at the time we make our decision.

What happens next if we deny your appeal?

If we deny any part of your appeal in Step 2, then your appeal *automatically* goes on to Step 3 where an independent organization will review your case. This independent review organization contracts with the federal government and is not part of Harvard Pilgrim. We will tell you in writing that your appeal has been sent to this organization for review. How quickly we must forward your appeal to the independent review organization that performs the review in Step 3 depends on the type of appeal:

1. *For a decision about payment for care you already received.*

   We must send all the information about your appeal to the independent review organization within 60 calendar days from the date we received your appeal in Step 2.

2. *For a standard decision about medical care.*

   We must send all of the information about your appeal to the independent review organization as quickly as your health requires, but no later than 30 calendar days after we received your appeal in Step 2.

3. *For a fast decision about medical care.*

   We must send all of the information about your appeal to the independent review organization within 24 hours of our decision.

STEP 3: If we deny any part of your appeal in Step 2, your appeal automatically goes on for review by a government-contracted independent review organization

What independent review organization does this review?

In Step 3, your appeal is given a new review by an outside, independent review organization that has a contract with CMS (Centers for Medicare & Medicaid Services), the government agency that runs the Medicare program. This organization has no connection to us. We will tell you when we have sent your appeal to this organization. You have the right to get a copy from us of your case file that we sent to this organization. We are allowed to charge you a fee for copying and sending this information to you.

How soon must the independent review organization decide?

After the independent review organization receives your appeal, how long the organization can take to make a decision depends on the type of appeal:

1. *For an appeal about payment for care,* the independent review organization has up to 60 calendar days to make a decision.

2. *For a standard appeal about medical care,* the independent review organization has up to 30 calendar days to make a decision. This time period can be extended by up to 14 calendar days if more information is needed and the extension will benefit you.

3. *For a fast appeal about medical care,* the independent review organization has up to 72 hours to make a decision. This time period can be extended by up to 14 calendar days if more information is needed and the extension will benefit you.

If the independent review organization decides completely in your favor:

The independent review organization will tell you in writing about its decision and the reasons for it. What happens next depends on the type of appeal:

1. *For an appeal about payment for care,* we must pay within 30 calendar days after receiving the decision.

2. *For a standard appeal about medical care,* we must *authorize* the care you have asked for within 72 hours after receiving notice of the decision from the independent review organization, or *provide* the care as quickly as your health requires, but no later than 14 calendar days after receiving the decision.

3. *For a fast appeal about medical care,* we must authorize or provide you with the care you have asked for within 72 hours of receiving the decision.

What happens next if the review organization decides against you (either partly or completely)?

The independent review organization will tell you in writing about its decision and the reasons for it. You may continue your appeal by asking for a review by an Administrative Law Judge (see Step 4), provided that the dollar value of the medical care or the payment in your appeal is $110 or more

You must make a request for review by an Administrative Law Judge in writing within 60 calendar days after the date you were notified of the decision made in Step 3. You can extend this deadline for good cause. You have a choice about where you send your written request:

- Directly to the independent review organization that reviewed your appeal in Step 3. They will then send your request along with your appeal information to the Administrative Law Judge who will hear your appeal.

- To Harvard Pilgrim, or to your local Social Security Administration office. If you do this, starting Step 4 will take longer because your request must first be forwarded to the independent review organization that reviewed your appeal in Step 3. The independent review organization will then send your request along with your appeal information to the Administrative Law Judge who will hear your appeal.

STEP 4: If the organization that reviews your case in Step 3 does not rule completely in your favor, you may ask for a review by an Administrative Law Judge

As stated in Step 3, if the independent review organization does not rule completely in your favor, you may ask them to forward your appeal for a review by an Administrative Law Judge. During this review, you may present evidence, review the record, and be represented by council. The Administrative Law Judge will not review the appeal if the dollar value of the medical care is less than $110. If the dollar value is less than $110, you may not appeal any further.

How soon does the Judge make a decision?

The Administrative Law Judge will hear your case, weigh all of the evidence up to this point, and make a decision as soon as possible.

If the Judge decides in your favor

We must pay for, authorize, or provide the service you have asked for within 60 calendar days from the date we receive notice of the decision. We have the right to appeal this decision by asking for a review by the Medicare Appeals Council (Step 5).

If the Judge rules against you

You have the right to appeal this decision by asking for a review by the Medicare Appeals Council (Step 5). The letter you get from the Administrative Law Judge will tell you how to request this review.

STEP 5: Your case may be reviewed by a Medicare Appeals Council

This Council will first decide whether to review your case

The Medicare Appeals Council does not review every case it receives. When it gets your case, it will first decide whether to review your case. If they decide not to review your case, then either you or Harvard Pilgrim may request a review by a Federal Court Judge. However, the Federal Court Judge will only review cases when the amount involved is $1,090 or more. If the dollar value is less than $1,090, you may not appeal any further.

How soon will the Council make a decision?

If the Medicare Appeals Council reviews your case, they will make their decision as soon as possible.

If the Council decides in your favor

We must pay for, authorize, or provide the medical service you have asked for within 60 calendar days from the date we receive notice of the decision. However, we have the right to appeal this decision by asking a Federal Court Judge to review the case (Step 6), provided the amount involved is at least $1,090. If the dollar value is less than $1,090, the Board's decision is final.

If the Council decides against you

If the amount involved is $1,090 or more, you or we have the right to continue your appeal by asking a Federal Court Judge to review the case (Step 6). If the value is less than $1,090, you may not take the appeal any further.

STEP 6: Your case may go to a Federal Court

If the contested amount is $1,090 or more, you or we may ask a Federal Court Judge to review the case.

Section 12 Appeals and grievances: What to do if you have complaints about your Part D prescription drug benefits

What to do if you have complaints

Introduction

We encourage you to let us know right away if you have questions, concerns, or problems related to your prescription drug coverage. Please call Member Services at the number on the cover of this booklet.

Please note that section 12 addresses complaints about your Part D prescription drug benefits. If you have complaints about your MA benefits, you must follow the rules outlined in sections 10 and 11.

This section gives the rules for making complaints in different types of situations. Federal law guarantees your right to make complaints if you have concerns or problems with any part of your care as a plan member. The Medicare program has helped set the rules about what you need to do to make a complaint and what we are required to do when we receive a complaint. If you make a complaint, we must be fair in how we handle it. You cannot be disenrolled from *First Seniority* or penalized in any way if you make a complaint.

A complaint will be handled as a grievance, coverage determination, or an appeal, depending on the subject of the complaint. The following section briefly discusses grievances, coverage determinations, and appeals.

What is a grievance?

A grievance is any complaint other than one that involves a coverage determination. You would file a grievance if you have any type of problem with *First Seniority* or one of our network pharmacies that does not relate to coverage for a prescription drug. For example, you would file a grievance if you have a problem with things such as waiting times when you fill a prescription, the way your network pharmacist or others behave, being able to reach someone by phone or get the information you need, or the cleanliness or condition of a network pharmacy.

What is a coverage determination?

Whenever you ask for a Part D prescription drug benefit, the first step is called requesting a coverage determination. When we make a coverage determination, we are making a decision whether or not to provide or pay for a Part D drug and what your share of the cost is for the drug. Coverage determinations include exceptions requests. You have the right to ask us for an "exception" if you believe you need a drug that is not on our list of covered drugs (formulary) or believe you should get a drug at a lower co-payment. If you request an exception, your physician must provide a statement to support your request.
You must contact us if you would like to request a coverage determination (including an exception). You cannot request an appeal if we have not issued a coverage determination.

What is an appeal?

An appeal is any of the procedures that deal with the review of an unfavorable coverage determination. You would file an appeal if you want us to reconsider and change a decision we have made about what Part D prescription drug benefits are covered for you or what we will pay for a prescription drug.

How to file a grievance

This part of Section 12 explains how to file a grievance. A grievance is different from a request for a coverage determination because it usually will not involve coverage or payment for Part D prescription drug benefits (concerns about our failure to cover or pay for a certain drug should be addressed through the coverage determination process discussed below).

What types of problems might lead to you filing a grievance?

- You feel that you are being encouraged to leave (disenroll from) *First Seniority*.
- Problems with the Member Services you receive.
- Problems with how long you have to spend waiting on the phone or in the pharmacy.
- Disrespectful or rude behavior by pharmacists or other staff.
- Cleanliness or condition of pharmacy.
- If you disagree with our decision not to expedite your request for an expedited coverage determination or redetermination.
- You believe our notices and other written materials are difficult to understand.
- Failure to give you a decision within the required timeframe.
- Failure to forward your case to the independent review entity if we do not give you a decision within the required timeframe.
- Failure by the Plan to provide required notices.
- Failure to provide required notices that comply with CMS standards.

In certain cases, you have the right to ask for a "fast grievance," meaning your grievance will be decided within 24 hours. We discuss these fast-track grievances in more detail below.

If you have a grievance, we encourage you to first call Member Services at the number on the cover of this booklet. We will try to resolve any complaint that you might have over the phone. If you request a written response to your phone complaint, we will respond in writing to you. **If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints.** We call this the Harvard Pilgrim grievance procedure. To use the formal grievance procedure, send your grievance in writing to Member Services. We must notify you of our decision about your grievance as quickly as your case requires based on your health status, but no later than 30 calendar days after receiving your complaint. We may extend the timeframe by up to 14 calendar days if you request the extension, or if we justify a need for additional information and the delay is in your best interest.

For quality of care complaints, you may also complain to the Quality Improvement Organization (QIO)

Complaints concerning the quality of care received under Medicare may be acted upon by the plan sponsor under the grievance process, by an independent organization called the QIO, or by both. For example, if an enrollee believes his/her pharmacist provided the incorrect dose of a prescription, the enrollee may file a complaint with the QIO in addition to or in lieu of a complaint filed under the plan sponsor's grievance

process. For any complaint filed with the QIO, the plan sponsor must cooperate with the QIO in resolving the complaint.

How to file a quality of care complaint with the QIO

Quality of care complaints filed with the QIO must be made in writing. An enrollee who files a quality of care grievance with a QIO is not required to file the grievance within a specific time period. See page 3 of the introduction for more information about how to file a quality of care complaint with the QIO.

How to request a coverage determination

This part of Section 12 explains what you can do if you have problems getting the prescription drugs you believe we should provide and you want to request a coverage determination. We use the word "provide" in a general way to include such things as authorizing prescription drugs, paying for prescription drugs, or continuing to provide a Part D prescription drug that you have been getting.

If your doctor or pharmacist tells you that *First Seniority* will not cover a prescription drug, you should contact us and ask for a coverage determination. The following are examples of when you may want to ask us for a coverage determination:

- If you are not getting a prescription drug that you believe may be covered by *First Seniority.*
- If you have received a Part D prescription drug you believe may be covered by *First Seniority* while you were a member, but we have refused to pay for the drug.
- If we will not provide or pay for a Part D prescription drug that your doctor has prescribed for you because it is not on our list of covered drugs (called a "formulary"). You can request an exception to our formulary. **See "How Can I Request an Exception" in section 6 for more information about the exceptions process.**
- If you disagree with the amount that we require you to pay for a Part D prescription drug that your doctor has prescribed for you. You can request an exception to the co-payment we require you to pay for a drug. **See "How Can I Request an Exception" in section 6 for more information about the exceptions process.**
- If you are being told that coverage for a Part D prescription drug that you have been getting will be reduced or stopped.
- If there is a limit on the quantity (or dose) of the drug and you disagree with the requirement or dosage limitation. **See "How Can I Request an Exception" in section 6 for more information about the exceptions process.**
- If there is a requirement that you try another drug before we will pay for the drug you are requesting. **See "How Can I Request an Exception" in section 6 for more information about the exceptions process.**
- You bought a drug at a pharmacy that is not in our network and you want to request reimbursement for the expense.

The process for requesting a coverage determination is discussed in greater detail below in the section titled "Detailed information about how to request a coverage determination and an appeal" (see page 81).

How to request an appeal

This part of Section 12 explains what you can do if you disagree with our coverage determination. If you are unhappy with the coverage determination, you can ask for an appeal. The first level of appeal is called a redetermination. There are also four other levels of appeal that an enrollee may request.

What kinds of decisions can be appealed?

You can generally appeal our decision not to cover a drug, vaccine, or other Part D benefit. You may also appeal our decision not to reimburse you for a Part D drug that you paid for. You can also appeal if you think we should have reimbursed you more than you received or if you are asked to pay a different cost-sharing amount than you think you are required to pay for a prescription. Finally, if we deny your exception request described in section 6 of this brochure, you can appeal. A coverage determination, which includes those described on page 82, may be appealed if you disagree with our decision.

Note: If we approve your exception request for a non-formulary drug, you cannot request an exception to the co-payment we require you to pay for the drug.

How does the appeals process work?

There are five levels to the appeals process. Here are a few things to keep in mind as you read the description of these steps in the appeals process:

- **Moving from one level to the next.** At each level, your request for Part D prescription drug benefits or payment is considered and a decision is made. The decision may be partly or completely in your favor (giving you some or all of what you have asked for), or it may be completely denied (turned down). If you are unhappy with the decision, there may be another step you can take to get further review of your request. Whether you are able to take the next step may depend on the dollar value of the requested drug or on other factors.
- **Who makes the decision at each level?** You make your request for coverage or payment of a Part D prescription drug directly to us. We review this request and make a coverage determination. If our coverage determination is to deny your request (in whole or in part), you can go on to the first level of appeal by asking us to review our coverage determination. If you are still dissatisfied with the outcome, you can ask for further review. If you ask for further review, your appeal is then sent outside of *First Seniority*, where people who are not connected to us conduct the review and make the decision. After the first level of appeal, all subsequent levels of appeal will be decided by someone who is connected to the Medicare program or the federal court system. This will help ensure a fair, impartial decision.

Each appeal level is discussed in greater detail below in the section titled "Detailed information about how to request a coverage determination and an appeal."

Detailed information about how to request a coverage determination and an appeal

What is the purpose of this section?

The purpose of this section is to give you more information about how to request a coverage determination, or appeal a decision by us not to cover or pay for all or part of a drug, vaccine or other Part D benefit.

Coverage Determinations: First Seniority makes a coverage determination about your Part D prescription drug, or about paying for a Part D prescription drug you have already received.

What is a coverage determination?

The coverage determination made by *First Seniority* is the starting point for dealing with requests you may have about covering or paying for a Part D prescription drug. If your doctor or pharmacist tells you that a certain prescription drug is not covered you should contact *First Seniority* and ask us for a coverage determination. With this decision, we explain whether we will provide the prescription drug you are requesting or pay for a prescription drug you have already received. If we deny your request (this is sometimes called an "adverse coverage determination"), you can "appeal" the decision by going on to Appeal Level 1 (see below). If we fail to make a timely coverage determination on your request, it will be automatically forwarded to the independent review entity for review (see Appeal Level 2 below).

The following are examples of coverage determinations:

- You ask us to pay for a prescription drug you have already received. This is a request for a coverage determination about payment. You can call us at **1-800-421-3550**, (for TTY call **1-800-421-3599**) to get help in making this request.
- You ask for a Part D drug that is not on your plan's list of covered drugs (called a "formulary"). This is a request for a "formulary exception." You can call us at **1-800-421-3550**, (for TTY call **1-800-421-3599**) to ask for this type of decision.
- You ask for an exception to our plan's utilization management tools - such as dosage limits, quantity limits, or step therapy requirements. Requesting an exception to a utilization management tool is a type of formulary exception. You can call us at **1-800-421-3550**, (for TTY call **1-800-421-3599**) to ask for this type of decision.
- You ask for a non-preferred Part D drug at the preferred cost-sharing level. This is a request for a "tiering exception." You can call us at **1-800-421-3550**, (for TTY call **1-800-421-3599**) to ask for this type of decision.
- You ask that we reimburse you for a purchase you made from an out-of-network pharmacy. In certain circumstances, out-of-network purchases, including drugs provided to you in a physician's office, will be covered by the plan. See page 34 for a description of these circumstances. You can call us at **1-800-421-3550**, (for TTY call **1-800-421-3599**) to make a request for payment or coverage for drugs provided by an out-of-network pharmacy or in a physician's office.

When we make a coverage determination, we are giving our interpretation of how the Part D prescription drug benefits that are covered for members of *First Seniority* apply to your specific situation. This booklet and any amendments you may receive describe the Part D prescription drug benefits covered by *First Seniority*, including any limitations that may apply to these benefits. This booklet also lists exclusions (benefits that are "not covered" by *First Seniority*).

Who may ask for a coverage determination?

You can ask us for a coverage determination yourself, or your prescribing physician or someone you name may do it for you. The person you name would be your *appointed representative*. You can name a relative, friend, advocate, doctor, or anyone else to act for you. Some other persons may already be authorized under State law to act for you. If you want someone to act for you, then you and that person must sign and date a

statement that gives the person legal permission to act as your appointed representative. This statement must be sent to us at Harvard Pilgrim Health Care, *First Seniority* Member Services, 1600 Crown Colony Drive, Quincy, MA 02169. You can call us at **1-800-421-3550**, (for TTY call **1-800-421-3599**) to learn how to name your appointed representative.

You also have the right to have an attorney ask for a coverage determination on your behalf. You can contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify.

Asking for a "standard" or "fast" coverage determination

Do you have a request for a Part D prescription drug that needs to be decided more quickly than the standard timeframe?

A decision about whether we will cover a Part D prescription drug can be a "standard" coverage determination that is made within the standard timeframe (typically within 72 hours; see below), or it can be a "fast" coverage determination that is made more quickly (typically within 24 hours; see below). A fast decision is sometimes called an "expedited coverage determination."

You can ask for a fast decision **only** if you or your doctor believe that waiting for a standard decision could seriously harm your health or your ability to function. (Fast decisions apply only to requests for Part D drugs that you have not received yet. You cannot get a fast decision if you are requesting payment for a Part D drug that you already received.)

Asking for a standard decision

To ask for a standard decision, you, your doctor, or your appointed representative should call us at **1-800-421-3550**, (for TTY call **1-800-421-3599**). Or, you can deliver a written request to Harvard Pilgrim Health Care, *First Seniority* Member Services, 1600 Crown Colony Drive, Quincy, MA 02169, or fax it to 1-617-509-3086. To deliver a request outside of regular weekday business hours, please fax your request to 1-617-509-3086.

Asking for a fast decision

You, your doctor, or your appointed representative can ask us to give a fast decision (rather than a standard decision) by calling us at **1-800-421-3550**, (for TTY call **1-800-421-3599**). Or, you can deliver a written request to Harvard Pilgrim Health Care, *First Seniority* Member Services, 1600 Crown Colony Drive, Quincy, MA 02169, or fax it to 1-617-509-3086. . To deliver a request outside of regular weekday business hours, please fax your request to 1-617-509-3086. Be sure to ask for a "fast," "expedited," or "24-hour" review.

- If your doctor asks for a fast decision for you, or supports you in asking for one, and the doctor indicates that waiting for a standard decision could seriously harm your health or your ability to function, we will automatically give you a fast decision.

- If you ask for a fast coverage determination without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast coverage determination, we will send you a letter informing you that if you get a doctor's support for a fast review, we will automatically give you a fast decision. The letter will also tell you how to file a "grievance" if you disagree with our decision to deny your request for a fast review. If we deny your request for a fast coverage determination, we will give you our decision within the 72 hour standard timeframe.

What happens when you request a coverage determination?

What happens, including how soon we must decide, depends on the type of decision.

1. **For a <u>standard</u> coverage determination about a Part D drug, which includes a request about payment for a Part D drug that you already received.**

   Generally, we must give you our decision no later than 72 hours after we have received your request, but we will make it sooner if your health condition requires. However, if your request involves a request for an exception (including a formulary exception, tiering exception, or an exception from utilization management rules – such as dosage or quantity limits or step therapy requirements), we must give you our decision no later than 72 hours after we have received your physician's "supporting statement," which explains why the drug you are asking for is medically necessary. If you are requesting an exception, you should submit your prescribing physician's supporting statement with the request, if possible.

   We will give you a decision in writing about the prescription drug you have requested. If we do not approve your request, we must explain why, and tell you of your right to appeal our decision. The section "Appeal Level 1" explains how to file this appeal.

   If you have not received an answer from us within 72 hours after receiving your request, your request will automatically go to Appeal Level 2, where an independent organization will review your case.

2. **For a <u>fast</u> coverage determination about a Part D drug that you have not received.**

   If you receive a fast review, we will give you our decision within 24 hours after you or your doctor ask for a fast review – sooner if your health requires. If your request involves a request for an exception, we will give you our decision no later than 24 hours after we have received your physician's "supporting statement," which explains why the non-formulary or non-preferred drug you are asking for is medically necessary.

   We will give you a decision in writing about the prescription drug you have requested. If we do not approve your request, we must explain why, and tell you of your right to appeal our decision. The section "Appeal Level 1" explains how to file this appeal.

   If we decide you are eligible for a fast review, and you have not received an answer from us within 24 hours after receiving your request, your request will automatically go to Appeal Level 2, where an independent organization will review your case.

   If we do not grant your or your physician's request for a fast review, we will give you our decision within the standard 72- hour timeframe discussed above. If we tell you about our decision not to provide a fast review by phone, we will send you a letter explaining our decision within three calendar days after we call you. The letter will also tell you how to file a “grievance” if you disagree with our decision to deny your request for a fast review, and will explain that we will automatically give you a fast decision if you get a doctor’s support for a fast review.

What happens if we decide completely in your favor?

If we make a coverage determination that is completely in your favor, what happens next depends on the situation.

1. **For a standard decision about a Part D drug, which includes a request about payment for a Part D drug that you already received.**

We must authorize or provide the benefit you have requested as quickly as your health requires, but no later than 72 hours after we received the request. If your request involves a request for an exception, we must authorize or provide the benefit no later than 72 hours after we have received your physician's "supporting statement." If you are requesting reimbursement for a drug that you already paid for and received, we must send payment to you no later than 30 calendar days after we receive the request.

2. For a <u>fast</u> decision about a Part D drug that you have not received.

We must authorize or provide you with the benefit you have requested no later than 24 hours of receiving your request. If your request involves a request for an exception, we must authorize or provide the benefit no later than 24 hours after we have received your physician's "supporting statement."

What happens if we deny your request?

If we deny your request, we will send you a written decision explaining the reason why your request was denied. We may decide *completely* or only *partly* against you. For example, if we deny your request for payment for a Part D drug that you have already received, we may say that we will pay nothing or only part of the amount you requested. If a coverage determination does not give you *all* that you requested, you have the right to appeal the decision. (See Appeal Level 1).

Appeal Level 1: If we deny part or all or part of your request in our coverage determination, you may ask us to reconsider our decision. This is called an "appeal" or "request for redetermination."

Please call us at **1-800-421-3550**, (for TTY call **1-800-421-3599**) if you need help with filing your appeal. You may ask us to reconsider our coverage determination, even if only part of our decision is not what you requested. When we receive your request to reconsider the coverage determination, we give the request to people at our organization who were not involved in making the coverage determination. This helps ensure that we will give your request a fresh look.

How you make your appeal depends on whether you are requesting reimbursement for a Part D drug you already received and paid for, or authorization of a Part D benefit (that is, a Part D drug that you have not yet received). If your appeal concerns a decision we made about authorizing a Part D benefit that you have not received yet, then you and/or your doctor will first need to decide whether you need a fast appeal. The procedures for deciding on a standard or a fast *appeal* are the same as those described for a standard or fast *coverage determination*. Please see the discussion under "Do you have a request for a Part D prescription drug that needs to be decided more quickly than the standard timeframe?" and "Asking for a fast decision

Getting information to support your appeal

We must gather all the information we need to make a decision about your appeal. If we need your assistance in gathering this information, we will contact you. You have the right to obtain and include additional information as part of your appeal. For example, you may already have documents related to your request, or you may want to get your doctor's records or opinion to help support your request. You may need to give the doctor a written request to get information.

You can give us your additional information in any of the following ways:

- In writing, to Harvard Pilgrim Health Care, *First Seniority* Member Services, 1600 Crown Colony Drive, Quincy, MA 02169
- By fax, at 1-617-509-3086.
- By telephone -- if it is a "fast" appeal -- at **1-800-421-3550**.

- In person, at Harvard Pilgrim Health Care, 1600 Crown Colony Drive, Quincy, MA 02169
- You also have the right to ask us for a copy of information regarding your appeal. You can call or write us at **1-800-421-3550**, (for TTY call **1-800-421-3599**); Harvard Pilgrim, 1600 Crown Colony Drive, Quincy MA 02169.

Who may file your appeal of the coverage determination?

The rules about who may file an appeal are almost the same as the rules about who may ask for a coverage determination. For a standard request, you or your appointed representative may file the request. A fast appeal may be filed by you, your appointed representative, or your prescribing physician.

How soon must you file your appeal?

You need to file your appeal within 60 calendar days from the date included on the notice of our coverage determination. We can give you more time if you have a good reason for missing the deadline.
To file a standard appeal, you can send the appeal to us in writing at Harvard Pilgrim Health Care, *First Seniority* Member Services, 1600 Crown Colony Drive, Quincy, MA 02169, or fax it to 1-617-509-3086.

What if you want a fast appeal?

The rules about asking for a fast appeal are the same as the rules about asking for a fast coverage determination. You, your doctor, or your appointed representative can ask us to give a fast appeal (rather than a standard appeal) by calling us at **1-800-421-3550**, (for TTY call **1-800-421-3599**). Or, you can deliver a written request to Harvard Pilgrim Health Care, *First Seniority* Member Services, 1600 Crown Colony Drive, Quincy, MA 02169, or fax it to 1-617-509-3086. To deliver a request outside of regular weekday business hours, please fax your request to 1-617-509-3086. Be sure to ask for a "fast," "expedited," or "72-hour" review. Remember, that if your prescribing physician provides a written or oral supporting statement explaining that you need the fast appeal, we will automatically treat you as eligible for a fast appeal.

How soon must we decide on your appeal?

How quickly we decide on your appeal depends on the type of appeal:

1. **For a standard decision about a Part D drug, which includes a request for reimbursement for a Part D drug you already paid for and received.**

   After we receive your appeal, we have up to 7 calendar days to give you a decision, but will make it sooner if your health condition requires us to. If we do not give you our decision within 7 calendar days, your request will automatically go to the second level of appeal, where an independent organization will review your case.

2. **For a fast decision about a Part D drug that you have not received.**

   After we receive your appeal, we have up to 72 hours to give you a decision, but will make it sooner if your health requires us to. If we do not give you our decision within 72 hours, your request will automatically go to Appeal Level 2, where an independent organization will review your case.

What happens next if we decide completely in your favor?

1. **For a decision about reimbursement for a Part D drug you already paid for and received.**

   We must send payment to you no later than 30 calendar days after we receive your request to reconsider our coverage determination.

2. **For a <u>standard</u> decision about a <u>Part D drug you have not received</u>.**

   We must authorize or provide you with the Part D drug you have asked for as quickly as your health requires, but no later than 7 calendar days after we received your appeal.

3. **For a <u>fast</u> decision about a <u>Part D drug you have not received</u>.**

   We must authorize or provide you with the Part D drug you have asked for within 72 hours of receiving your appeal – or sooner, if your health would be affected by waiting this long.

What happens next if we deny your appeal?

If we deny any part of your appeal, you or your appointed representative have the right to ask an independent organization, to review your case. This independent review organization contracts with the federal government and is not part of *First Seniority*.

Appeal Level 2: If we deny any part of your first appeal, you may ask for a review by a government-contracted independent review organization

What independent review organization does this review?

At the second level of appeal, your appeal is reviewed by an outside, independent review organization that has a contract with the **C**enters for **M**edicare & Medicaid **S**ervices (CMS), the government agency that runs the Medicare program. The independent review organization has no connection to us. You have the right to ask us for a copy of your case file that we sent to this organization.

How soon must you file your appeal?

You or your appointed representative must make a request for review by the independent review organization <u>in writing</u> within 60 calendar days after the date you were notified of the decision on your first appeal. You must send your written request to the independent review organization whose name and address is included in the redetermination you receive from *First Seniority*.

What if you want a fast appeal?

The rules about asking for a fast appeal are the same as the rules about asking for a fast coverage determination, except your prescribing physician cannot file the request for you – only you or your appointed representative may file the request. If you want to ask for a fast appeal, please follow the instructions under "Asking for a fast decision." Remember, if your prescribing physician provides a written or oral supporting statement explaining that you need the fast appeal, the IRE will automatically treat you as eligible for a fast appeal.

How soon must the independent review organization decide?

After the independent review organization receives your appeal, how long the organization can take to make a decision depends on the type of appeal:

1. For a <u>standard</u> request about a <u>Part D drug</u>, <u>which includes a request about reimbursement</u> for a Part D drug that you already paid for and received, the independent review organization has up to 7 calendar days from the date it received your request to give you a decision.

2. For a <u>fast</u> decision about a <u>Part D drug that you have not received</u>, the independent review organization has up to 72 hours from the time it receives the request to give you a decision.

If the independent review organization decides completely in your favor:

The independent review organization will tell you in writing about its decision and the reasons for it. What happens next depends on the type of appeal:

1. **For a decision about reimbursement for a Part D drug you already paid for and received.**
   We must pay within 30 calendar days from the date we receive notice reversing our coverage determination. We will also send the independent review organization a notice that we have abided by their decision.

2. **For a <u>standard</u> decision about a <u>Part D drug you have not received</u>.**
   We must authorize or provide you with the Part D drug you have asked for within 72 hours from the date we receive notice reversing our coverage determination. We will also send the independent review organization a notice that we have abided by their decision.

3. **For a <u>fast</u> decision about a <u>Part D drug you have not received</u>.**
   We must authorize or provide you with the Part D drug you have asked for within 24 hours from the date we receive notice reversing our coverage determination. We will also send the independent review organization a notice that we have abided by their decision.

What happens next if the review organization decides against you (either partly or completely)?

The independent review organization will tell you in writing about its decision and the reasons for it. You or your appointed representative may continue your appeal by asking for a review by an Administrative Law Judge (see Appeal Level 3), provided that the dollar value of the contested Part D benefit is $110 or more.

Appeal Level 3: If the organization that reviews your case in Appeal Level 2 does not rule completely in your favor, you may ask for a review by an Administrative Law Judge

As stated above, if the independent review organization does not rule completely in your favor, you or your appointed representative may ask for a review by an Administrative Law Judge. You must make a request for review by an Administrative Law Judge <u>in writing</u> within 60 calendar days after the date of the decision made at Appeal Level 2. You may request that the Administrative Law Judge extend this deadline for good cause. You must send your <u>written</u> request to the office specified in the IRO's reconsideration letter.

During the Administrative Law Judge review, you may present evidence, review the record (by either receiving a copy of the file or accessing the file in person when feasible), and be represented by counsel. The Administrative Law Judge will not review your appeal if the dollar value of the requested Part D benefit is less than $110. If the dollar value is less than $110, you may not appeal any further.

How is the dollar value (the "amount remaining in controversy") calculated?

If we have refused to provide Part D prescription drug benefits, the dollar value for requesting an Administrative Law Judge hearing is based on the projected value of those benefits. The projected value includes any costs you could incur based on the number of refills prescribed for the requested drug during the plan year. Projected value includes your co-payments, all expenditures incurred after your expenditures exceed the initial coverage limit, and expenditures paid by other entities.

You may also combine multiple Part D claims to meet the dollar value if:

1. The claims involve the delivery of Part D prescription drugs to you;
2. All of the claims have received a determination by the independent review organization as described in Appeal Level 2;
3. Each of the combined requests for review are filed in writing within 60 calendar days after the date that each decision was made at Appeal Level 2; and
4. Your hearing request identifies all of the claims to be heard by the Administrative Law Judge.

How soon does the Judge make a decision?

The Administrative Law Judge will hear your case, weigh all of the evidence up to this point, and make a decision as soon as possible.

If the Judge decides in your favor:

The Administrative Law Judge will tell you in writing about his or her decision and the reasons for it. What happens next depends on the type of appeal:

1. *For a decision about payment for a Part D drug you already received.*
   We must send payment to you no later than 30 calendar days from the date we receive notice reversing our coverage determination.
2. *For a standard decision about a Part D drug you have not received.*
   We must authorize or provide you with the Part D drug you have asked for within 72 hours from the date we receive notice reversing our coverage determination.
3. *For a fast decision about a Part D drug you have not received.*
   We must authorize or provide you with the Part D drug you have asked for within 24 hours from the date we receive notice reversing our coverage determination.

If the Judge rules against you:

You have the right to appeal this decision by asking for a review by the Medicare Appeals Council (Appeal Level 4). The letter you get from the Administrative Law Judge will tell you how to request this review.

Appeal Level 4: Your case may be reviewed by the Medicare Appeals Council

The Medicare Appeals Council will first decide whether to review your case. There is no minimum dollar value for the Medicare Appeals Council to hear your case. If you got a denial at Appeal Level 3, you or your appointed representative can request review by filing a written request with the Council.

The Medicare Appeals Council does not review every case it receives. When it gets your case, it will first decide whether to review your case. If they decide not to review your case, then you may request a review by a Federal Court Judge (see Appeal Level 5). The Medicare Appeals Council will issue a written notice advising you of any action taken with respect to you request for review. The notice will tell you how to request a review by a Federal Court Judge.

How soon will the Council make a decision?

If the Medicare Appeals Council reviews your case, they will make their decision as soon as possible.

If the Council decides in your favor:

The Medicare Appeals Council will tell you in writing about its decision and the reasons for it. What happens next depends on the type of appeal:

1. *For a decision about payment for a Part D drug you already received.*
   We must send payment to you no later than 30 calendar days from the date we receive notice reversing our coverage determination.

2. *For a standard decision about a Part D drug you have not received.*
   We must authorize or provide you with the Part D drug you have asked for within 72 hours from the date we receive notice reversing our coverage determination.

3. *For a fast decision about a Part D drug you have not received.*
   We must authorize or provide you with the Part D drug you have asked for within 24 hours from the date we receive notice reversing our coverage determination.

If the Council decides against you:

If the amount involved is $1,090 or more, you have the right to continue your appeal by asking a Federal Court Judge to review the case (Appeal Level 5). The letter you get from the Medicare Appeals Council will tell you how to request this review. If the value is less than $1,090, the Council's decision is final and you may not take the appeal any further.

Appeal Level 5: Your case may go to a Federal Court

In order to request judicial review of your case, you must file a civil action in a United States district court. The letter you get from the Medicare Appeals Council in Appeal Level 4 will tell you how to request this review. The Federal Court Judge will first decide whether to review your case.
If the contested amount is $1,090 or more, you may ask a Federal Court Judge to review the case.

How soon will the Judge make a decision?

The Federal judiciary is in control of the timing of any decision.

If the Judge decides in your favor:

Once we receive notice of a judicial decision in your favor, what happens next depends on the type of appeal:

1. *For a decision about payment for a Part D drug you already received.*
   We must send payment to you within 30 calendar days from the date we receive notice reversing our coverage determination.

2. *For a standard decision about a Part D drug you have not received.*
   We must authorize or provide you with the Part D drug you have asked for within 72 hours from the date we receive notice reversing our coverage determination.

3. *For a fast decision about a Part D drug you have not received.*
   We must authorize or provide you with the Part D drug you have asked for within 24 hours from the date we receive notice reversing our coverage determination.

If the Judge decides against you:

The Judge's decision is final and you may not take the appeal any further.

SECTION 13 Leaving *First Seniority* and your choices for continuing Medicare after you leave

What is "disenrollment"?

"Disenrollment" from *First Seniority* means **ending your membership** in *First Seniority*. Disenrollment can be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave *First Seniority* because you have decided that you *want* to leave. You can do this for any reason. However, as we explain in this section, **there are limits to <u>when</u> you may leave, <u>how often</u> you can make changes, and what type of plan you can join after you leave.** In such an event, you should contact the Group Insurance Commission's benefits administrator directly.

- There are also a few situations where you would be *required* to leave. For example, you would have to leave *First Seniority* if you move permanently out of our geographic service area or if *First Seniority* leaves the Medicare program. We are not allowed to ask you to leave the plan because of your health.

Whether leaving the plan is your choice or not, this section explains your Medicare coverage choices after you leave and the rules that apply.

Until your membership ends, you must keep getting your Medicare services through First Seniority or you will have to pay for them yourself

If you leave *First Seniority*, it may take some time for your membership to end and your new way of getting Medicare to take effect (we discuss when the change takes effect later in this section). While you are waiting for your membership to end, you are still a member and must continue to get your care as usual through *First Seniority*.

If you get services from doctors or other medical providers who are **not** plan providers before your membership in *First Seniority* ends, neither Harvard Pilgrim nor the Medicare program will pay for these services, with just a few exceptions. The exceptions are urgently needed care, care for a medical emergency, out-of-area renal (kidney) dialysis services, and care that has been approved by us. There is another possible exception, if you happen to be hospitalized on the day your membership ends. If this happens to you, call Member Services at the number on the cover of this booklet to find out if your hospital care will be covered by *First Seniority*. If you have any questions about leaving *First Seniority*, please call us at Services.

What are your choices for receiving your Medicare services if you leave <u>First Seniority</u> if you are enrolled in First Seniority with Prescription Drug coverage?

- If you leave *First Seniority*, you should contact the Group Insurance Commission's benefits administrator to find out all the options that are available to you. One choice for continuing with Medicare is to join a **Medicare Advantage plan or other Medicare Health Plan** *if* any of these types of plans are available in your area, and if they are accepting new members. You can also choose the **Original Medicare plan.** If you choose Original Medicare, you must choose a Prescription Drug Plan if you wish to continue to have Medicare prescription drugs coverage.

- **Original Medicare** is available throughout the country. It is a "fee-for-service" health plan that lets you go to any doctor, hospital, or other health care provider *who accepts Medicare*. You must pay a deductible. Then Medicare pays its share of the Medicare-approved amount, and you pay your share.

Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance). If you choose Original Medicare and you want to continue to get Medicare prescription drug coverage, you will need to enroll in one of the **Prescription Drug Plans** that are available in your area. These plans only cover prescription drugs (not other benefits or services). If you switch to Original Medicare between January 1, 2006 and June 30, 2006 (see "When and how often can you change your Medicare choices?" below), you may be required to join one of these plans if you join Original Medicare.

- **Other Medicare** Advantage Plans (including HMOs such as *First Seniority* or PPOs) are available in some parts of the country. In HMOs you go to the doctors, hospitals, and other providers *that are part of the plan*. In PPOs, you can usually see any doctor but you may pay more to see doctors, hospitals, and other providers that are *not* part of the plan. These plans must cover all Medicare Part A and Part B health care. Some plans cover extras, like prescriptions drugs as part of the Medicare Part D (Prescription Drug) benefit. *First Seniority* is a Medicare Advantage Plan offered by Harvard Pilgrim.
- **Medicare Private Fee-for-Service Plans** are available in some parts of the country. In Private Fee-for-Service plans, you may go to *any* Medicare-approved doctor or hospital that accepts the plan's payment. The Private Fee-for-Service plan, rather than the Medicare program, decides how much it pay and what you pay – for the services you will get. You may pay more for Medicare-covered benefits. You may get extra benefits that Original Medicare does not cover, like prescriptions drugs as part of the Medicare Part D (Prescription Drug) benefit. (See "When and how often can you change your Medicare choices?") Private Fee-for-Service plans are *not* the same as Medigap (Medicare supplement insurance) policies.

What are your choices for receiving your Medicare services if you leave First Seniority if you are not enrolled in First Seniority *with Prescription Drug coverage?*

If you leave *First Seniority*, one choice for continuing with Medicare is to join another **Medicare Advantage Plan** or a **Medicare Private Fee-for-Service plan** *if* any of these types of plans are available in your area, and are accepting new members. You can also choose to go to **Original Medicare.**

- **Original Medicare** is available throughout the country. It is a pay-per-visit or "fee-for-service" health plan that lets you go to any doctor, hospital, or other health care provider *who accepts Medicare*. You must pay a deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance).
- **Medicare Advantage Plans** (such as HMOs or PPOs) are available in some parts of the country. In HMOs you go to the doctors, hospitals, and other providers *that are part of the plan*. In PPOs, you can usually see any doctor but you may pay more to see doctors, hospitals, and other providers that are *not* part of the plan. These plans must cover all Medicare Part A and Part B health care. Some plans cover extras, like prescriptions drugs as part of the Medicare Part D (Prescription Drug) benefit. You may only change during certain times of the year (see "When and how often can you change your Medicare choices?" below).
- **Medicare Private Fee-for-Service Plans** are available in some parts of the country. In Private Fee-for-Service plans, you may go to any Medicare-approved doctor or hospital that accepts the plan's payment. The Private Fee-for-Service plan, rather than the Medicare program, decides how much it pays and what you pay for the services you will get. You may pay more for Medicare-covered benefits. You may get extra benefits that Original Medicare does not cover, like prescriptions drugs as part of the Medicare Part D (Prescription Drug) benefit. For more information on when you can make changes see "When and how often can you change your Medicare choices?" below. Fee-for-Service plans are not the same as Medigap (Medicare supplement insurance) policies.

When and how often can you change your Medicare choices, and what choices can you make?

Starting in 2006, there are limits to when and how often you can change the way you get Medicare and what choices you can make when you make the change.

Here are the new rules:

1. From November 15, 2005 through May 15, 2006, anyone with Medicare will have two chances to switch from one way of getting Medicare to another.
2. From January 1, 2006 until June 30, 2006, anyone with Medicare has another chance to make one change in the way they get Medicare.

   With this chance, you are limited in the type of plan you may join. If you have Medicare prescription drug coverage when making your change, you will only be able to join a Medicare Advantage Plan or Medicare Private Fee-For-Service plan that offers the Medicare Part D (Prescription Drug), or you will have to go to Original Medicare and join a Prescription Drug Plan. If you do not have Medicare prescription drug coverage when making this change, you will only be able to join a Medicare Advantage Plan or Private Fee-For-Service plan that does not offer the Medicare Part D (Prescription Drug), or go to Original Medicare.
3. Generally, you can't make any other changes during the year unless you meet special exceptions, such as if you move or if you have Medicaid coverage contact us for information. Later in the year, from November 15 through December 31, anyone with Medicare can switch their way of getting Medicare to another way for the following year.

In most cases, your disenrollment date will be the first day of the month that comes *after* the month we receive your request to leave. For example, if we receive your request to leave during the month of February, your disenrollment date will be March 1.

What should you do if you decide to leave First Seniority?

If you want to leave *First Seniority*:

- First, contact the Group Insurance Commission's benefits administrator to find out what your options are.
- Then, as explained below, what you must do to leave First Seniority depends on whether you want to switch to Original Medicare or to one of your other choices.
- Then be sure that the type of change you want to make and when you want to make it fit with the new rules explained above about changing how you get Medicare. If the change does not fit with these rules, you won't be allowed to make the change.

How to change from First Seniority to Original Medicare

Do you need to join a Prescription Drug Plan?

- *Original Medicare does not cover very many prescription drugs outside of a hospital. So, if you want to change from First Seniority to Original Medicare*, contact the Group Insurance Commission to find out what your options are. You should think about whether you want to also join a Medicare Prescription Drug Plan. It is important to know that if you are eligible to join a prescription drug plan and you do not, you may have to pay a higher premium when you do join. To get information about Prescription Drug Plans that you can join, you can call 1-800-MEDICARE (1-800-633-4227), which is the national Medicare help line. TTY Users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.

Keep in mind that if you change from *First Seniority* to Original Medicare, the only times that you can also join a Prescription Drug Plan are from January 1, 2006 to May 15, 2006, from November 15, to December 31, or during a special enrollment period as described in "When and how often can you change your Medicare choices and what choices can you make during these times?"

Do you need to buy a Medigap (Medicare supplement insurance) policy?

If you want to change from *First Seniority* to Original Medicare, you should think about whether you need to buy a Medigap policy to supplement your Original Medicare coverage. For Medigap advice, you should contact Serving Health Information Needs of Elders (SHINE) (the phone number is in Section 1). You can ask SHINE about how and when to buy a Medigap policy if you need one. SHINE can tell you if you have a guaranteed issue right to buy a Medigap policy.

If you are at least 65 and have been eligible for Part B for less than six months, you may still be in your Medigap open enrollment period. If you leave our plan while you are still in your open enrollment period, and you do not have a guaranteed issue right, the Medigap insurer can refuse to sell you a policy, or impose limits based on your health. If you have a "**guaranteed issue right,**" this means that for a limited period the Medigap insurer must sell you a Medigap policy, even if you have health problems. This is a special, temporary right, which means that if you decide to change to Original Medicare, in certain situations you have a limited time to buy a Medigap policy on a guaranteed issue basis. For example, you have a guaranteed issue right to buy a Medigap policy if you are in a trial period." You may be in a trial period if, in the past 12 months you: (1) dropped a Medigap policy to join *First Seniority* or Medicare health plan for the first time; or (2) joined *First Seniority* another Medicare health plan when you first became entitled to Medicare at age 65. Under certain circumstances, if you lose your health plan coverage while you are still in a trial period, the trial period can last for an extra 12 months. SHINE can tell you about other situations where you may have guaranteed issue rights. You may also have a guaranteed issue right if you move out of our service area, or if we stop providing Medicare benefits.

If you do want to buy a Medigap policy, you have to follow the instructions below for changing from *F*irst Seniority to Original Medicare. (Buying a Medigap policy does not switch you from *First Seniority* to Original Medicare. In fact, while you are still enrolled in *First Seniority* it is against the law for A Medigap insurance company to sell you a policy. A Medigap sales person or insurance agent cannot cancel your *First Seniority* membership and put you in Original Medicare.)

How to change from First Seniority to Original Medicare

First, contact the Group Insurance Commission's benefits administrator to find out what your options are. If you decide to change from *First Seniority* to Original Medicare, you must tell us or Medicare that you want to leave *First Seniority*. You do *not* have to enroll in Original Medicare, because you will automatically be in Original Medicare when you leave *First Seniority*. Here is how it works:

1. First, use any of the following ways to tell us that you want to leave *First Seniority*:
    - You can write or fax a letter to us or fill out a disenrollment form and send it to Enrollment and Billing at 1600 Crown Colony Drive, Quincy, MA 02269-9777. Be sure to sign and date your letter or form. To get a disenrollment form, call us at the Member Services telephone number on the cover of this booklet.
    - You can call 1-800-MEDICARE (1-800-633-4227), which is the national Medicare help line. TTY Users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.

2. We will then send you a letter that tells you when your membership will end. This is your **disenrollment date** – the day you officially leave *First Seniority*. In most cases, your disenrollment date will be the first day of the month that comes after the month we receive your request to leave. For example, if we receive your request to leave during the month of February, your disenrollment date will be March 1. Remember, while you are waiting for your membership to end, you are still a member of *First Seniority* and must continue to get your medical care as usual through *First Seniority*.

3. On your disenrollment date, your membership in *First Seniority* ends and you can start using your red, white, and blue Medicare card to get services under Original Medicare**.** You will not get anything in writing that tells you that you have Original Medicare, because you will *automatically* be in Original Medicare when you leave *First Seniority*. (Call Social Security at 1-800-772-1213 if you need a new red, white, and blue Medicare card.)

How to change from *First Seniority* to another Medicare Advantage Plan or to a Private Fee-for-Service Plan

First, contact the Group Insurance Commission's benefits administrator to find out what your options are. If you want to change from *First Seniority* to a different Medicare Advantage plan, including a Private Fee-for-Service plan, here is what to do:

1. Contact the plan you want to join to be sure it is accepting new members. Also ask the plan if it offers the Medicare Part D prescription drug benefit. Remember, if the plan does not offer the Part D benefit, you can only join it from January 1, 2006 to May 15, 2006, from November 15, 2006 to December 31, 2006 or during an "exception for special circumstances," as described in "When and how often can you change your Medicare choices and what choices can you make during these times?

2. Your new plan will tell you the date when your membership in that plan begins, and your membership in *First Seniority* will end on that same day (this will be your "disenrollment date"). Remember, you are still a member until your disenrollment date, and must continue to get your medical care as usual through *First Seniority* until the date your membership ends.

3. Your new plan will tell you the date when your membership in that plan begins, and your membership in *First Seniority* will end on that same day (this will be your "disenrollment date"). Remember, you are still a member until your disenrollment date, and must continue to get your medical care as usual through *First Seniority* until the date your membership ends.

What happens to you if Harvard Pilgrim leaves the Medicare program or *First Seniority* leaves the area where you live?

If we leave the Medicare program or change our service area so that it no longer includes the area where you live, we will tell you in writing. If this happens, your membership in *First Seniority* will end, and you will have to change to another way of getting your Medicare benefits. All of the benefits and rules described in this booklet will continue until your membership ends. This means that you must continue to get your medical care in the usual way through *First Seniority* until your membership ends.

In such an event, you should contact the Group Insurance Commission directly. Your choices for how to get your Medicare will always include Original Medicare and joining a Prescription Drug Plan to complement your Original Medicare coverage. Your choices may also include joining another Medicare Advantage Plan, or a Private Fee-for-Service plan, if these plans are available in your area and are accepting new members. Once we have told you in writing that we are leaving the Medicare program or the area where you live, you will have a chance to change to another way of getting your Medicare benefits. If you decide to change from *F*irst Seniority to Original Medicare, you will have the right to buy a Medigap policy regardless of your health. This is called a "guaranteed issue right" and it is explained earlier in this section under the heading, "Do you need to buy a Medigap (Medicare supplement insurance) policy?"

Harvard Pilgrim has a contract with the Centers for Medicare & Medicaid Services (CMS), the government agency that runs Medicare. This contract renews each year. At the end of each year, the contract is reviewed, and either Harvard Pilgrim or CMS can decide to end it. You will get 90 days advance notice in this situation. It is also possible for our contract to end at some other time during the year, too. In these situations we will try to tell you 90 days in advance, but your advance notice may be as little as 30 or fewer days if CMS must end our contract in the middle of the year.

Whenever a Medicare health plan leaves the Medicare program or stops serving your area, you will be provided a special enrollment period to make choices about how you get Medicare, including choosing a Medicare Prescription Drug Plan and guaranteed issue rights to a Medigap policy.

You must leave *First Seniority* if you move out of the service area or are away from the service area for more than six months in a row

If you plan to move or take a long trip, please call Member Services at the number on the cover of this booklet to find out if the place you are moving to or traveling to is in *First Seniority's* service area. If you move permanently out of our service area, or if you are away from our service area for more than six months in a row, you generally cannot remain a member of *First Seniority*. In these situations, if you do not leave on your own, we must end your membership ("disenroll" you). An earlier part of this section tells about the choices you have if you leave *First Seniority* and explains how to leave.

Under certain conditions Harvard Pilgrim can end your membership and make you leave the plan

We *cannot* ask you to leave the plan because of your health

No member of any Medicare health plan can be asked to leave the plan for any health-related reasons. If you ever feel that you are being encouraged or asked to leave *First Seniority* because of your health, you should call 1-800-MEDICARE (1-800-633-4227), which is the national Medicare help line. TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.

We *can* ask you to leave the plan under certain special conditions

If any of the following situations occur, we will end your membership in Harvard Pilgrim.

- If you move out of our geographic service area or live outside the plan's service area for more than six months at a time (see Section 2 for information about the plan's service area).
- If you do *not* stay continuously enrolled in both Medicare Part A and Medicare Part B (see Section 8 for information about staying enrolled in Part A and Part B).
- If you give us information on your enrollment form that you know is false or deliberately misleading, and it affects whether or not you can enroll in *First Seniority*.
- If you behave in a way that is disruptive, to the extent that your continued enrollment seriously impairs our ability to arrange or provide medical care for you or for others who are members of *First Seniority*. We cannot make you leave *First Seniority* for this reason unless we get permission first from the Centers for Medicare & Medicaid Services, the government agency that runs Medicare.
- If you let someone else use your plan membership card to get medical care. If you are disenrolled for this reason, CMS may refer your case to the Inspector General; for additional investigation.
- If you do not pay the plan premiums, we will tell you in writing that you have a one month grace period during which you can pay the plan premiums before you are required to leave *First Seniority*.

You have the right to make a complaint if we ask you to leave Harvard Pilgrim

If we ask you to leave *First Seniority*, we will tell you our reasons in writing and explain how you can file a complaint against us if you want to.

SECTION 14 Legal Notices

Notice about governing law

Many different laws apply to this Benefit Handbook. Some additional provisions may apply to your situation because they are required by law. This can affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other federal laws may apply and, under certain circumstances, the laws of the State(s) of Massachusetts or New Hampshire may apply.

Notice about non-discrimination

When we make decisions about the provision of health care services, we do not discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare Advantage plans, like Harvard Pilgrim, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that receive federal funding, and any other laws and rules that apply for any other reason.

Access to Information

The Member agrees that, except where restricted by law, Harvard Pilgrim may have access to (a) all health record and medical data from health care providers covered under this Benefit Handbook and (b) information concerning health coverage or claims from all providers of motor vehicle insurance, medical payment policies, home owners insurance and all types of health benefit plans that pertains to services you receive while a member of *First Seniority*. Harvard Pilgrim will comply with all laws restricting access to special types of medical information, including, but not limited to, HIV test data, drug and alcohol abuse rehabilitation record and mental health services.

Confidentiality

Harvard Pilgrim is committed to ensuring and safeguarding the confidentiality of its members' personal and medical information in all settings. Harvard Pilgrim staff access, use and disclose members' personal information only in connection with providing services and benefits and in accordance with Harvard Pilgrim's confidentiality policies. Harvard Pilgrim permits only designated employees, who are trained in the proper handling of member information, to have access to and use of your information. Harvard Pilgrim sometimes contracts with other organizations or entities to assist with the delivery of care or administration of benefits. Any such entity must agree to adhere to Harvard Pilgrim's confidentiality and privacy standards.

When you enrolled with Harvard Pilgrim, you consented to disclosures which are necessary for the provision and administration of services and benefits, such as: coordination of care, including referrals and authorizations; conducting quality activities, including member satisfaction surveys and disease management programs; verifying eligibility: fraud detection and certain oversight reviews, such as accreditation. When Harvard Pilgrim uses or discloses your personal information, it does so using the minimum amount of information necessary to accomplish the specific activity.

Harvard Pilgrim discloses its members' personal information only: (1) in connection with the delivery of care or administration of benefits, such as utilization review, quality assurance activities and third-party reimbursement by other payers, including self-insured employer groups; (2) when you specifically authorize the disclosure; (3) in connection with certain activities allowed under law, such as research and fraud

detection; (4) when required by law; or (5) as otherwise allowed under the terms of your Benefit Handbook. Whenever possible, Harvard Pilgrim discloses member information without member identifiers and in all cases only discloses the amount of information necessary to achieve the purpose for which it was disclosed. Harvard Pilgrim will not disclose to other third parties, such as employers, member-specific information (i.e. information from which you are personally identifiable) without your specific consent unless permitted by law or as necessary to accomplish the types of activities described above.

Harvard Pilgrim and all of its contacted health care providers agree to provide members' access to, and a copy of, their medical records upon a member's request. In addition, your medical records cannot be released to a third party without your consent or unless permitted by law.

If you have any questions about the Harvard Pilgrim confidentiality policies you may contact the *First Seniority* Member Services Department at **1-800-421-3550**. Hours of operation are 8:00 a.m. to 7:30 p.m. on Monday and Wednesday and 8:00 a.m. to 5:30 p.m. on Tuesday, Thursday and Friday. A Member Services representative will be happy to assist you. If you are hearing impaired, please call **1-800-421-3599** for TTY service.

Evaluation of New Technology

The Plan covers medical devices; diagnostic, medical and surgical procedures and drugs as described in this Benefit Handbook, Summary of Benefits, and if applicable, the Prescription Drug Brochure. This includes new devices, procedures and drugs, as well as those with new applications, as long as they are not Experimental or Unproven.

Harvard Pilgrim has a specialized team that evaluates diagnostics, medical therapies, surgical procedures, medical devices and drugs. The team manages the evidence-based evaluation process from initial inquiry to final policy recommendation. The team researches the safety and effectiveness of these new technologies by reviewing published medical reports, literature, expert consultation with practitioners, and benchmarking. The team presents its recommendations to internal policy committees responsible for making decisions regarding coverage of the new technology under the Plan.*

*For *First Seniority* Members, Medicare Covered Services are determined per Medicare coverage guidelines and local medical review policies.

Member Notices (Mailing Address)

Any notice to a Member will be sent to the last address of the Member on file with Harvard Pilgrim. Notice of a change of address should be sent to Harvard Pilgrim at the address listed on page 1 of this Benefit Handbook.

Modification of This Benefit Handbook

This Benefit Handbook and the Enrollment Form comprise the entire contract between you and Harvard Pilgrim. It can only be modified in writing by an authorized officer of Harvard Pilgrim with approval from CMS. No other action by Harvard Pilgrim, including the deliberate non-enforcement of any benefit limit, shall be deemed to waive or alter any part of this Benefit Handbook. Changes can be made on an annual basis. Changes made during the year can only result in an increase of benefits or decrease in copayment for you and must be approved in advance by CMS.

Relationship of First Seniority Providers and Harvard Pilgrim

The relationship of Harvard Pilgrim to providers, other than Harvard Pilgrim employees, is governed by separate agreements. They are independent contractors. Such providers may not modify this Benefit Handbook or create any obligation for Harvard Pilgrim. Harvard Pilgrim is not liable for statements about this Benefit Handbook by them, their employees or agents.

Benefits in The Event of Other Insurance

Payments for Harvard Pilgrim benefits under this Benefit Handbook will be coordinated with benefits available under the Member's other insurance policies, including but not limited to motor vehicle insurance, medical payment policies, home owners insurance, health insurance and self-insured health benefits programs. One plan shall have primary obligation for services; the other plan(s) shall have secondary obligation. No duplication shall occur in payment for or rendering of services. Benefits will be paid in accordance with Medicare guidelines and requirements.

Workers' Compensation/Government Programs

If Harvard Pilgrim has information indicating that services provided to a Member are covered under Workers' Compensation, employer's liability or other program of similar purpose or by a federal, state or other government agency, Harvard Pilgrim may suspend payment for such services until a determination is made whether payment will be made by such program.

If Harvard Pilgrim provides or pays for services for an illness or injury covered under Workers' Compensation, employer's liability or other program of similar purpose or by a federal, state or other government agency, Harvard Pilgrim will be entitled to recovery of its expenses from the provider of services or the party or parties legally obligated to pay for such services.

Medical Payment Policies

For Members who are entitled to benefits under the medical payment benefit of a motor vehicle, motorcycle, boat, homeowners, hotel, restaurant or other insurance policy, such coverage shall become primary to the coverage under this Benefit Handbook for services rendered in connection with a covered loss under that policy. The benefits under this Benefit Handbook shall not duplicate any benefits to which the Member is entitled under any medical payment policy or benefit. All sums payable for services provided under this Benefit Handbook to Members that are covered under any medical payment policy or benefit are payable by Harvard Pilgrim.

Member Cooperation

The Member agrees to cooperate with Harvard Pilgrim in exercising its rights of subrogation and coordination of benefits under this Benefit Handbook. Such cooperation will include, but not be limited to: a) the provision of all information and documents requested by Harvard Pilgrim; b) the execution of any instruments deemed necessary by Harvard Pilgrim to protect its rights; c) the prompt assignment to Harvard Pilgrim of any monies received for services provided or paid for by Harvard Pilgrim and d) the prompt notification to Harvard Pilgrim of any instances that may give rise to Harvard Pilgrim's rights. The Member further agrees to do nothing to prejudice or interfere with Harvard Pilgrim's rights to subrogation or coordination of benefits.

Harvard Pilgrim's Rights

Nothing in this Benefit Handbook shall be construed to limit Harvard Pilgrim's right to utilize any remedy provided by law to enforce its rights to subrogation or coordination of benefits under this Benefit Handbook.

SECTION 15 Definitions of some words used in this booklet

For the terms listed below, this section either gives a definition or directs you to a place in this booklet that explains the term

Acute Hospital – Any hospital other than a Long Term Hospital, a Rehabilitation Hospital or a Psychiatric Hospital.

Appeal – Any of the procedures that deal with the review of adverse initial decisions on the health care services a member is entitled to receive or any amounts that the member must pay for a covered service. These procedures include reconsiderations by Harvard Pilgrim, review by an independent outside organization, hearings before Administrative Law Judges (of the Social Security Administration), review by the Departmental Appeals Board, and judicial review. Sections 10 and 11 explain about appeals, including the process involved in making an appeal.

Benefit Period – For both *First Seniority* and Original Medicare, a Benefit Period is used to determine coverage for inpatient stays in hospitals and skilled nursing facilities. A Benefit Period *begins* on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The Benefit Period *ends* when you have not been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one Benefit Period has ended, a new Benefit Period begins. There is no limit to the number of Benefit Periods you can have. The type of care you actually receive during the stay determines whether you are considered to be an inpatient for SNF stays, but not for hospital stays.

- You are an inpatient in a SNF only if your care in the SNF meets certain skilled level of care standards. Specifically, in order to have been an inpatient while in a SNF, you must need daily skilled nursing or skilled rehabilitation care, or both. (Section 7 tells what is meant by skilled care.)
- Generally, you are an inpatient of a hospital if you are receiving inpatient services in the hospital (the type of care you actually receive in the hospital does not determine whether you are considered to be an inpatient in the hospital).

Brand Name Drug –. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are not available until after the patent on the brand name drug has expired.

Calendar Year – The period that begins on January 1 and ends twelve (12) consecutive months later on December 31.

Centers for Medicare & Medicaid Services (CMS) – The Federal Agency that runs the Medicare program (CMS was formerly known as the Health Care Financing Administration). Section 1 tells how you can contact CMS.

Copayment – a payment you make for your share of the cost of certain Covered Services you receive. A Copayment is **a set amount per service** (such as paying $10 for *a doctor visit*). You pay your copayment when you get the service. The Benefits Chart in Section 4 gives your Copayments for Covered Services. Section 4 and 6 gives your Copayments for prescription drugs.

Co-insurance – a payment you make for your share of the cost of certain covered services you receive. Co-insurance is **a *percentage* of the cost of the service** (such as paying 50% for a *doctor visit*). You pay your co-insurance when you get the service. The Benefits Chart in Section 4 gives your co-insurance for covered services. Section 4 and 6 gives your Co-insurance for prescription drugs.

Coverage Determination – Harvard Pilgrim has made a coverage determination when it makes a decision about the prescription drug benefits you can receive under the plan, and the amount that you must pay for a drug.

Covered Services – The general term we use in this booklet to mean all of the health care services and supplies that are covered by *First Seniority*. Covered Services are listed in the Benefits Chart in Section 4.

Creditable Coverage – Coverage that is at least as good as the standard Medicare prescription drug coverage.

Custodial Care – Care furnished for the purpose of meeting non-medically necessary personal needs which could be provided by persons without professional skills or training, such as assistance in walking, dressing, bathing, eating, preparation of special diets, and taking medication. Custodial care is not covered by *First Seniority* or Original Medicare unless provided with skilled nursing care and/or skilled rehabilitation services.

Disenroll or Disenrollment – The process of ending your membership in *First Seniority*. Disenrollment can be voluntary (your own choice) or involuntary (not your own choice). Section 12 tells about disenrollment.

Durable Medical Equipment – is equipment needed for medical reasons, which is sturdy enough to be used many times without wearing out. A person normally needs this kind of equipment only when ill or injured. It can be used in the home. Examples of durable medical equipment include wheelchairs, hospital beds, or equipment that supplies a person with oxygen.

Emergency Medical Condition – A medical condition brought on by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect that not getting immediate medical attention could result in 1) Serious jeopardy to the health of the individual (or, in the case of a pregnant woman, the health of the woman or her unborn child); 2) Serious impairment to bodily functions; or 3) Serious dysfunction of any bodily organ or part.

Emergency care – Covered Services that are 1) furnished by a provider qualified to furnish emergency services; and 2) needed to evaluate or stabilize an emergency medical condition. Section 3 tells about emergency services.

Evidence of Coverage and Disclosure Information (also known as the Benefit Handbook) – This document, along with your enrollment form explains the Covered Services, defines our obligations, and explains your rights and responsibilities as a member of the *First Seniority*.

Exception – A type of coverage determination that, if approved, allows you to obtain a drug that is not on our formulary (a formulary exception), or receive a non-preferred drug at the preferred cost-sharing level (a tiering exception). You may also request an exception if we require you to try another drug before receiving the drug you are requesting, or the plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

Exclusion – Items or services that *First Seniority* does not cover. You are responsible for paying for excluded items or services.

Experimental Procedures and Items – Items and procedures determined by Medicare not to be generally accepted by the medical community. When deciding if a service or item is experimental, Harvard Pilgrim will follow the Centers for Medicare & Medicaid Services' manuals or will follow decisions already made by Medicare. With the exception of procedures and items under approved clinical trials, experimental procedures and items are not covered under this Benefit Handbook.

Formulary – A list of covered drugs provided by the plan.

Generic Drug – A prescription drug that has the same active-ingredient formula as a brand name drug. Generic drugs usually cost less than brand name drugs and are rated by the **F**ood and **D**rug **A**dministration (FDA) to be as safe and effective as brand name drugs.

Grievance – Any complaint or dispute other than one involving an "initial decision." Examples of issues that involve a complaint that will be resolved through the grievance rather than the appeal process include: waiting times in physician offices and rude or unresponsive Member Services staff. Section 10 explains about grievances.

Home Health Agency – A Medicare-certified agency that provides skilled nursing care and other therapeutic services in your home when medically necessary.

Hospice – A Medicare-certified organization or agency that is primarily engaged in providing pain relief, symptom management and supportive services to terminally ill people and their families.

Hospital – A Medicare-certified institution licensed by the State, that provides inpatient, outpatient, emergency, diagnostic and therapeutic services. The term "hospital" does not include a convalescent nursing home, rest facility or facility for the aged that primarily provides custodial care, including training in routines of daily living.

Hospital Day - Any day of a Benefit Period during which *First Seniority* or Original Medicare covered your inpatient care in an Acute, Rehabilitation, Long Term or Psychiatric Hospital, excluding the day of discharge.

Hospitalist – A physician who specializes in treating patients when they are in the hospital and who may coordinate a patient's care when he or she is admitted at a *First Seniority* hospital.

Initial decision – In general, a decision by Harvard Pilgrim, or a person acting on Harvard Pilgrim's behalf, to approve or deny a payment for a service or a request for provision of service made by you or on your behalf.

Lock-In – An arrangement under which all Covered Services, except emergency services, urgently needed services, or out-of-area renal dialysis services, must be provided or authorized by your Plan Provider or your PCP. If you get any other services from a non-plan provider or a Plan Provider such as a specialist without prior authorization, neither Harvard Pilgrim nor Original Medicare will pay for that care. (There are very limited exceptions to this rule, including the right to self-refer for Flu Shots and Mammography Screening services. See the Schedule of Medical Benefits in Section 5 for specific limitations that apply to self-referral for these benefits).

Long Term Hospital – A Long Term Hospital (sometimes called a "Chronic Hospital") is a hospital authorized to care for Medicare beneficiaries that specialize in caring for patients on a long-term basis. For the purpose of this Benefit Handbook, a hospital will be considered a Long Term Hospital if it is classified as a Long Term Hospital under Medicare Regulations (42 CFR Section 412.23). Long Term Hospitals have an average inpatient length of stay greater than 25 days and serve patients that often require services that cannot be provided in most Skilled Nursing Facilities.

Medical Director – A licensed physician who is responsible for the overall quality of the medical care we provide.

Inpatient Care – Health care that you get when you are admitted to a hospital.

Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you don't join a plan when you're first able. You pay this higher amount as long as you have Medicare. There are some exceptions. If you do not have creditable prescription drug coverage, you will have to pay a penalty in addition to your monthly plan premium.

Medically necessary – Services or supplies that are proper and needed for the diagnosis or treatment of your medical condition; are used for the diagnosis, direct care, and treatment of your medical condition; meet the standards of good medical practice in the local community; and are not mainly for the convenience of you or your doctor.

Medicare – The federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage Organization – A public or private organization licensed by the State as a risk-bearing entity that is under contract with the Centers for Medicare & Medicaid Services (CMS) to provide Covered Services. Medicare Advantage Organizations can offer one or more Medicare Advantage Plans. Harvard Pilgrim is a Medicare Advantage Organization. (Medicare Advantage is the new name for Medicare+Choice).

Medicare Advantage Plan – A benefit package offered by a Medicare Advantage Organization that offers a specific set of health benefits at a uniform premium and uniform level of cost-sharing to all people with Medicare who live in the service area covered by the Plan. A Medicare Advantage Organization may offer more than one plan in the same service area. *First Seniority* is a Medicare Advantage Plan. (Medicare Advantage is the new name for Medicare+Choice).

Medicare Cost Plan – A specific set of health benefits offered at a uniform premium and uniform level of cost-sharing to all people with Medicare living in the service area covered by the Plan. A company offering a Cost Plan may offer more than one plan in the same service area. Members under this plan may use Original Medicare benefits from any Medicare provider.

Medicare Managed Care Plan – Means a Medicare Advantage HMO, Medicare Cost Plan, or Medicare Advantage PPO.

Medicare Prescription Drug Coverage – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part B.

"Medigap" (Medicare supplement insurance) policy – Many people who get their Medicare through Original Medicare buy "Medigap" or Medicare supplement insurance policies to fill "gaps" in Original Medicare coverage.

Member (member of *First Seniority*, or "plan member") – A person with Medicare who is eligible to get Covered Services, who has enrolled in *First Seniority*, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Member services – A department within Harvard Pilgrim responsible for answering your questions about your membership, benefits, grievances, and appeals. See Section 1 for information about how to contact Member Services. A *First Seniority* Member Services representative is available to assist you during regular business hours by calling **1-800-421-3550**, TTY/TDD: **1-800-421-3599**, (Hours of operation are 8:00 a.m. - 7:30 p.m. on Monday and Wednesday, and 8:00 a.m. - 5:30 p.m. on Tuesday, Thursday and Friday.)

Network – A group of health care providers under contract with Harvard Pilgrim that is licensed and/or certified by Medicare with the purpose of delivering or furnishing health care services. Generally, Member must receive routine services within their designated network in order to be covered by Harvard Pilgrim.

Network Pharmacy – A network pharmacy is a pharmacy where members of our Plan can receive covered prescription drug benefits. We call them "network pharmacies" because they contract with our Plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Non-Plan Provider or Non-Plan Facility – A provider or facility that we have **not** arranged with to coordinate or provide Covered Services to members of *First Seniority*. Non-plan providers are providers that are not employed, owned, or operated by Harvard Pilgrim and are not under contract to deliver Covered Services to you. As explained in this booklet, most services you get from non-plan providers are not covered by Harvard Pilgrim or Original Medicare.

Office Visit – A visit for Covered Services to your PCP, specialist, other Plan Provider or non-plan provider upon referral.

Organization Determination - The MA organization has made an organization determination when it, or one of its providers, makes a decision about MA services or payment that you believe you should receive.

Original Medicare – A plan that is available everywhere in the United States. Some people call it "traditional Medicare" or "fee-for-service" Medicare. Original Medicare is the way most people get their Medicare Part A and Part B health care. It is the national pay-per-visit program that lets you go to any doctor, hospital, or other health care provider *who accepts Medicare*. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance).

Out-of-Network Pharmacy – A pharmacy that we have not arranged with to coordinate or provide covered drugs to members of our Plan. As explained in this Evidence of Coverage, most services you get from non-network pharmacies are not covered by our Plan unless certain conditions apply. See Section 1.

Part D – The voluntary Prescription Drug Benefit Program. (For ease of reference, we will refer to the new prescription drug benefit program as Part D.)

Part D Drugs – Any drug that can be covered under a Medicare Prescription Drug Plan. Generally, any drug not specifically excluded under Medicare drug coverage is considered a Part D Drug.

Physician Hospital Organization (PHO) – A contracting organization that requires physicians to use a specific hospital. In most cases, all hospital services, except for emergency and urgently needed services, must be obtained from the hospital with which your PCP is affiliated.

Plan Hospital – A hospital that has a contract with Harvard Pilgrim or your plan medical group or IPA to give you services and/or supplies.

Plan Medical Group – Physicians organized as a legal entity to provide medical care. The plan medical group has an agreement with Harvard Pilgrim to provide medical services to you.

Plan Pharmacy – See "Network Pharmacy" definition

Plan Premium – The monthly payment to Harvard Pilgrim that entitles you to the Covered Services outlined in this Benefit Handbook. (Note: To qualify for the services outlined in this Benefit Handbook, you must also pay the monthly Medicare Part B Premium and, if applicable, Medicare Part A Premiums.)

Plan Provider – "Provider" is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. We call them "Plan Providers" when they are part of *First Seniority*. When we say that Plan Providers are "part of *First Seniority*," this means that we have arranged with them to coordinate or provide Covered Services to members of *First Seniority*. Harvard Pilgrim pays Plan Providers based on the contracts it has with the providers.

Pharmacy Benefits Manager (PBM) – Companies that contract with Medicare Advantage Organizations to manage pharmacy services.

Primary Care *Physician* (PCP) – A health care professional who is trained to give you basic care. Your PCP is responsible for providing or authorizing Covered Services while you are a plan member. Section 2 tells more about PCPs.

Prior Authorization – Approval in advance to get services. Some services are covered only if your doctor or other Plan Provider gets "prior authorization" from Harvard Pilgrim. Covered Services that need prior authorization are marked in the Benefits Chart.

Provider – A doctor, hospital, health care professional or health care facility licensed and/or certified by the State or Medicare to deliver or furnish health care services. See "Plan Provider", above.

Psychiatric Hospital – An institution providing inpatient psychiatric care for the diagnosis and treatment of mental illness that is certified by Medicare as a Psychiatric Hospital.

Quality Improvement Organization (QIO) – Groups of practicing doctors and other health care experts who are paid by the Federal Government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by doctors in inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Private fee-for-service plans and ambulatory surgical centers. See Section 1 for information about how to contact the QIO in your state and Section 10 for information about making complaints to the QIO.

Referral – Your PCP's approval for you to see a certain specialist or to receive certain Covered Services.

Rehabilitation Services – These services include physical therapy, cardiac rehabilitation, speech and language therapy, and occupational therapy that are provided under the direction of a Plan Provider. See Section 7 for more information.

Rehabilitative Hospital – A Rehabilitative Hospital is a hospital authorized to care for Medicare beneficiaries that specializes in providing intensive rehabilitation services to its patients. For the purposes of this Benefit Handbook, a hospital will be considered a Rehabilitative Hospital if it is classified as a Rehabilitative Hospital under Medicare regulations (42 CFR Section 412.23 (b)).

Service Area – Section 2 tells about *First Seniority*'s service area. "Service area" is the geographic area approved by the Centers for Medicare & Medicaid Services (CMS) within which an eligible individual may enroll in a particular plan offered by a Medicare Health Plan.

Skilled Nursing Care – Services that can only be performed by or under the supervision of licensed nursing personnel.

Skilled Nursing Facility (SNF) – A facility (or distinct part of a facility) which is primarily engaged in providing to its residents skilled nursing or rehabilitation services and is certified by Medicare. The term "skilled nursing facility" does not include a convalescent nursing home, rest facility or facility for the aged in which furnishes primarily custodial care, including training in routines of daily living.

Specialist – A doctor who provides health care services for a specific disease or part of the body. Examples include oncologists (care for cancer patients), cardiologists (care for the heart), and orthopedists (care for bones).

Urgently needed care – Section 3 explains about urgently needed services. These are different from emergency services.

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